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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
_____ DIVISION

U.S. NEWS & WORLD REPORT, L.P. Plaintiff, vs. **DAVID CHIU**, in his Official Capacity as City Attorney of the City and County of San Francisco, Defendant.	Case No. _____ **COMPLAINT FOR INJUNCTIVE RELIEF AND A DECLARATORY JUDGMENT** **JURY TRIAL DEMANDED**

Introduction

1. The First Amendment to the United States Constitution safeguards the freedom of speech and the freedom of the press against viewpoint-based discrimination by the government. The Liberty of Speech Clause in the California Constitution, Art. I, § 2, similarly protects these foundational rights. And California's Reporters' Shield Law, embodied in the California Constitution (Art. I, § 2, subd. (b)) and California law (Cal. Evid. Code § 1070), defends the press against intrusive inquiries by the government into unpublished information, newsgathering, and methodologies.

2. Despite these bedrock protections, San Francisco's City Attorney David Chiu (the "City Attorney") is now investigating and issuing burdensome subpoenas to Plaintiff U.S. News & World Report, L.P. ("U.S. News") because he disagrees with U.S. News' viewpoint and methodology (which is publicly available) for arriving at U.S. News' rankings. Specifically, the City Attorney disapproves of U.S. News' rigorous and well-respected Best Hospital rankings. It is flatly unconstitutional for the City Attorney to harass U.S. News due to his differing views on these rankings; his mounting harassment must be put to a stop.

3. At its core, the City Attorney's actions pose a fundamental threat to our First Amendment rights and set a dangerous precedent for all media platforms and news organizations. The City Attorney is threatening invasive, sweeping,

burdensome incursions against a news organization merely because he disagrees with an editorial viewpoint – specifically, U.S. News' rankings and methodology. The independence of editorial determinations—free from business considerations—is a bedrock principle of journalism, to which U.S. News proudly adheres.

4. U.S. News firmly stands behind its hospital rankings as a valuable and reliable public resource for individuals and families making critical decisions about medical care for themselves and their loved ones.

5. Throughout its storied 90 year history, U.S. News has been a news organization that has consistently maintained the highest level of journalistic integrity. U.S. News has won a variety of prestigious awards, including multiple National Magazine Awards and other recognition from the Society of Professional Journalists, Investigative Reporters and Editors, the National Press Club, and the Overseas Press Club of America. Its mission has been and remains to equip its readers and consumers with the information needed to make important life decisions. Over the decades, U.S. News has learned that its readers consume information in different formats, which led to the development of robust ranking systems based on multiple data sources, compiled and summarized with rigor and journalistic expertise. For over 34 years, U.S. News has provided hospital rankings to recognize excellence in healthcare services and provide important information to healthcare consumers. U.S. News maintains fidelity to its mission of helping consumers make

the best healthcare decisions and operates according to the highest journalistic standards.

6. On June 20, 2023, and with no prior warning, the City Attorney sent U.S. News a demand letter (attached hereto as Exhibit A) criticizing the results of U.S. News' hospital rankings and seeking information about U.S. News' ranking methodology, purportedly under the auspices of the California Business and Professions Code section 17508. The City Attorney claimed (incorrectly) that the rankings "suffer from poor and opaque methodology" and questioned U.S. News' claim that it is the "global authority in hospital rankings." In a thorough response dated July 19, 2023 (Ex. B), U.S. News raised grave, pointed concerns about the City Attorney's infringement on U.S. News' rights under the United States and California Constitutions and California's Reporters' Shield Laws, while also explaining that its ranking methodology is published annually, communicated widely, and is wholly transparent.

7. When U.S. News did not receive any further correspondence from the City Attorney for nearly six months, it reasonably assumed that the City Attorney's misguided inquiry was at an end. It was not.

8. On January 9, 2024, the City Attorney inexplicably returned and escalated his intrusive inquiry by issuing, without notice, two subpoenas seeking documents and information relating to U.S. News' hospital rankings (the

"Subpoenas"). Exs. D, E. The Subpoenas mark an unconstitutional intrusion into U.S. News' journalistic practices, motivated by the City Attorney's disapproval of U.S. News' viewpoint regarding which hospitals deserve to be ranked higher than others.

9. The Subpoenas make clear that the City Attorney is using governmental process to engage in viewpoint discrimination—and, indeed, is proceeding as though he holds censorial (or editorial) authority over how U.S. News performs its journalistic work ranking hospitals. The Subpoenas ask U.S. News to "[d]escribe [U.S. News'] basis for not including measures of health equity in its rankings of adult Hospitals"; "[d]escribe how, if at all, [U.S. News] has incorporated primary and preventive care in each annual version of the Best Hospitals rankings"; and "[d]escribe [U.S. News'] basis for believing that Medicare outcomes information from at least 18 months ago accurately reflects current Hospital outcomes."

10. Simply put, the City Attorney believes his office has the power to second-guess and redirect the journalistic decision-making of U.S. News based on his own view of what factors should and should not be considered. This is the same power that governmental censors and licensors had claimed over the press until the Framers of the U.S. Constitution enshrined the First Amendment more than 200 years ago in order to abolish any such power. Because the City Attorney today is flouting the First Amendment's protection of Freedom of Expression and the

Freedom of the Press along with California's Constitution, U.S. News is respectfully seeking injunctive and declaratory relief.

11. If the City Attorney's actions are allowed to stand, any journalistic enterprise that provides analyses or opinions to the public—analyses or opinions that elected officials may wish to fault—may for that reason be subject to subpoena and investigation. Government actors who disagree with any form of journalism, including articles, rankings, product reviews, editorials, op-eds, or even political cartoons, may feel free to use their powers of investigation to harass, reshape, and chill those views. Such actions are an affront to the foundational freedoms upon which our Constitution and nation are built.

12. Forcing U.S. News to respond to the Subpoenas would violate the core right of U.S. News to be free from viewpoint-based discrimination by the government. Defendant's adverse government action implicates U.S. News' fundamental rights both as a private speaker and a world-renowned journalistic enterprise. It thus falls to this Court to vindicate the freedoms of speech and of the press embedded in the First Amendment and the Liberty of Speech Clause.

13. Faced with violation and chilling of First Amendment freedoms, U.S. News has been forced to bring this suit pursuant to 42 U.S.C. §§ 1983 and 1988 and 28 U.S.C. §§ 2201-02 to obtain injunctive and declaratory relief to secure its rights,

privileges, and immunities under the United States Constitution, the California Constitution, and California's Reporters' Shield Laws.

14. Specifically, U.S. News seeks a declaration that the Subpoenas violate the First and Fourteenth Amendments to the United States Constitution, Article I, section 2 of the California Constitution, and section 1070 of the California Evidence Code. U.S. News also seeks an order permanently enjoining Defendant from enforcing the Subpoenas.

Parties

15. U.S. News is a privately held company that, for over 90 years, has been a leading journalistic institution with a reputation for fact-based and data-driven reporting. U.S. News is famous for, among other things, providing trusted rankings of colleges, graduate schools, hospitals, states, countries, and healthiest communities. There are tens of millions of visitors to U.S. News' website, usnews.com, every month, consisting of people seeking research and guidance.

16. Defendant David Chiu is the City Attorney of the City and County of San Francisco. In that capacity, he exercises enforcement authority on behalf of the City and County of San Francisco and holds ultimate authority over the Subpoenas and any actions to force compliance with same.

Jurisdiction

17. This case presents federal questions within this Court's jurisdiction pursuant to Article III of the United States Constitution and 28 U.S.C. §§ 1331 and 1343(3). U.S. News brings this action pursuant to 42 U.S.C. §§ 1983 and 1988 (deprivation of rights, privileges, and immunities secured by the Constitution and federal law) and 28 U.S.C. §§ 2201-02 (declaratory judgment as to an actual controversy).

Divisional Assignment

18. This civil action should be assigned to the San Francisco division. Defendant is the City Attorney for the City and County of San Francisco, and a substantial part of the events giving rise to the claims occurred in San Francisco.

Venue

19. Venue in this Court is proper under 28 U.S.C. § 1391(b).

Facts

I. BACKGROUND OF U.S. NEWS AND ITS METHODOLOGY FOR HOSPITAL RANKINGS

20. U.S. News has been ranking hospitals for 34 years. Its "Best Hospital" rankings are broken into two subcomponents — specialty rankings and procedure and condition ratings.

21. The specialty rankings are meant for patients with life-threatening or rare conditions who need a hospital that excels in treating complex, high-risk cases.

Hospitals are ranked from 1 to 50 in most specialties, with hospitals not in the top 50 but still in the top 10% of all rated hospitals in those specialties receiving a designation of "high performing."

22. The procedure and condition ratings, meanwhile, focus on specific and more commonly required individual procedures and conditions, such as hip replacement and heart failure, rather than on broader specialties like orthopedics and cardiology. The goal for these rankings is to evaluate how well hospitals perform in each procedure or condition—not just for the most challenging cases, as with the specialty rankings, but across the full range of patients. Because the procedures and conditions evaluated are performed at many more hospitals than the specialties, the evaluations produce ratings rather than numerical rankings. Hospitals that treat enough patients to be evaluated are rated one of three ways for each procedure or condition: high performing, average, or below average.

23. In 2023, U.S. News evaluated thousands of hospitals across 15 specialties and 21 procedures.

24. U.S. News provides its Best Hospital rankings to recognize excellent healthcare facilities and to provide the public with an informed view of the relative strengths of particular hospitals. As stated on U.S. News' website, the rankings are intended to be taken as a "starting point," and "[a]ll care decisions should be made

in conjunction with medical professionals."[1] Depending on any particular individual's health situation, it might make more sense to go to an average hospital that is close by or in-network for insurance purposes rather than a high-performing hospital that is far away and out-of-network.

25. The methodology used to produce each year's Best Hospitals rankings is updated and refined on an annual basis by a team of professionals and journalists led by a Managing Editor and a Senior Health Data Scientist. Each member of the editorial team works full time on health rankings, including the hospital rankings. Editorial team members are not involved in sales of any products or services and revenue considerations do not impact the rankings in any way.

26. In formulating its rankings, U.S. News has contracted for nearly 20 years with an independent, nonprofit research institute to support the publication of Best Hospitals: Specialty Rankings and Best Children's Hospitals. Additionally, U.S. News has from time to time contracted with other professional organizations to support its analytical work.

27. The process that U.S. News' editorial team uses to iteratively refine its methodology is designed to be responsive to stakeholder feedback, advances in

[1] Ben Harder, *FAQ: How and Why We Rank and Rate Hospitals*, U.S. News Dec. 5, 2023, *available at* https://health.usnews.com/health-care/best-hospitals/articles/faq-how-and-why-we-rank-and-rate-hospitals (last visited Jan. 23, 2024).

measurement science, and changes in how healthcare is delivered to beneficiaries of America's largest insurance plan, Medicare. This process entails long-standing journalistic practices that includes judgment and evidentiary rigor.

28. Stakeholder feedback is an essential component of the journalistic process, and the team obtains feedback via multiple modalities, including: (1) working groups comprising medical experts; (2) U.S. News-convened focus groups of healthcare consumers; (3) U.S. News-initiated interaction with medical researchers and study authors; (4) memoranda and letters submitted by specialty societies, hospital consortia, researchers, clinicians, patients, patient advocate groups, hospital and health system administrators, and other stakeholders; (5) professional meetings at which U.S. News staff present and receive feedback; (6) U.S. News-hosted conferences and webinars in which U.S. News staff present and receive feedback; and (7) other miscellaneous communications with stakeholders. All of this unpublished information obtained during U.S. News' editorial process is protected by the First Amendment and California's Reporters' Shield Law.

29. Advances in measurement science are identified by: (1) reading peer-reviewed studies published in relevant scientific journals, such as the Journal of the American Medical Association, Health Affairs, and Health Services Research; (2) speaking with and corresponding with researchers about the methods they have used in such studies; and (3) conducting independent scientific research.

30. Relevant changes in healthcare delivery are identified by studying policy announcements issued by the Centers for Medicare and Medicaid Services, as well as studying data, whether issued by other groups or derived internally, to understand changing trends in how and where diseases are treated and how treatments are documented in the data sets available for our analysis.

31. The U.S. News team curates the feedback received and identifies candidate methodology changes that, in its members' opinions, are likely to improve the precision with which the methodology identifies high-performing hospitals.

32. U.S. News publishes, along with the actual rankings, reports that describe in detail the methodologies underlying each of its Best Hospital rankings for that year. Examples of these reports are attached hereto as Exhibits G and H. In particular, the reports describe the changes that have been made from the prior year's methodology, the data that is collected/used, the weighting of the data and criteria, the expert opinion component to the rankings, and even methodological improvements that are being considered for future years. These detailed methodology reports are available for downloading so that anyone can see the methodology used for a particular ranking in any particular year.

33. U.S. News gives no weight to financial considerations when determining and publishing its rankings. Higher rankings cannot be bought at any sum, as this would fatally undermine U.S. News' standing as a leader in unbiased,

quality-driven rankings. While U.S. News accepts advertising and other revenues from entities that may be ranked—just as television networks and newspapers regularly accept ads from businesses that are the subject of news stories—such advertising plays no role in the rankings. Ranked entities have the option to license a "badge" to highlight their placement on the rankings on their own website and in their own advertisements, a practice followed by many other publications. The licensing of badges is common in the publishing industry. The licensing of the badge has absolutely no connection with the rankings an entity may receive.

34. U.S. News is just one of many publications that provide rankings and/or ratings to the public, both about hospitals and otherwise. The Wall Street Journal,[2] The San Francisco Chronicle,[3] Newsweek,[4] The L.A. Times,[5] The New York Times'

[2] *2024 Best Colleges in the U.S.*, WALL STREET JOURNAL, *available at* https://www.wsj.com/rankings/college-rankings/best-colleges-2024 (last visited Jan. 23, 2024).

[3] Cesar Hernandez and Soleil Ho, *Top 25 Restaurants,* SAN FRANCISCO CHRONICLE, Jan. 15, 2024, *available at* https://www.sfchronicle.com/projects/2023/best-sf-restaurants-bay-area/ (last visited Jan. 23, 2024).

[4] *World's Best Hospitals 2023*, NEWSWEEK, *available at* https://www.newsweek.com/rankings/worlds-best-hospitals-2023/united-states (last visited Jan. 23, 2024).

[5] Bill Addison, *The 101 Best Restaurants in Los Angeles of 2023,* LOS ANGELES TIMES, Dec. 5, 2023, *available at* https://www.latimes.com/food/list/101-best-los-angeles-restaurants-ranked-2023 (last visited Jan. 23, 2024).

Wirecutter,[6] Forbes,[7] Consumer Reports,[8] Better Homes and Gardens,[9] CNET,[10] Money.com,[11] and countless other websites, newspapers, and magazines offer rankings, reviews, and "best of" lists to their readers. If the City Attorney's actions are permitted to stand, the overreach threatens to chill all media, not just U.S. News.

II. U.S. NEWS' HOSPITAL RANKINGS ARE WIDELY RECOGNIZED AS A VALUABLE RESOURCE

35. Numerous third-party evaluations by experts in the healthcare industry support U.S. News' view that its hospital rankings are a valuable and trusted resource for the public. Most notably, in 2019, health researchers writing in the New England Journal of Medicine (long renowned as one of the world's most respected and influential medical journals) bestowed upon U.S. News the highest grade among the hospital rankings they evaluated.[12] The researchers conducted a comprehensive

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[6] New York Times Wirecutter, *available at* https://www.nytimes.com/wirecutter/ (last visited Jan. 23, 2024).

[7] *Forbes Lists,* FORBES, *available at* https://www.forbes.com/lists/list-directory/ (last visited Jan. 23, 2024).

[8] CONSUMER REPORTS, *available at* https://www.consumerreports.org/ (last visited Jan. 23, 2024).

[9] *BHG Recommends*, BETTER HOMES & GARDENS, *available at* https://www.bhg.com/shopping/bhg-recommends/ (last visited Jan. 23, 2024).

[10] *Best* Products, CNET, *available at* https://www.cnet.com/best/ (last visited Jan. 23, 2024).

[11] *The Best Hospitals of 2024*, MONEY, *available at* https://money.com/best-hospitals/ (last visited Jan. 23, 2024).

[12] Karl Y. Bilimoria, et al., *Rating The Raters: An Evaluation Of Publicly Reported Hospital Quality Rating Systems*, NEW ENG. J. OF MED. CATALYST, Aug. 14, 2019, *available at* https://catalyst.nejm.org/doi/full/10.1056/CAT.19.0629 (last visited Jan. 23, 2024).

study to evaluate various hospital ranking systems, including the federal government's CMS Hospital Compare Overall Star Ratings, Healthgrades Top Hospitals, Leapfrog Safety Grade and Top Hospitals, and U.S. News. The study involved a group of experienced methodologists, consisting of physician scientists who bring expertise in healthcare quality measurement from academic centers and the private sector. The study established six major criteria for assessing these rating systems: Potential for Misclassification of Hospital Performance, Importance/Impact, Scientific Acceptability, Iterative Improvement, Transparency, and Usability. The assessment aimed to identify strengths, weaknesses, and opportunities for improvement in the rating systems. This rigorous study spanned several months and aimed to provide users with valuable insights into the different rating systems, ultimately aiding in their decision-making process.

36. U.S. News emerged as the health researchers' top-ranking system. It surpassed even the U.S. Government's own rating system, Hospital Compare. The New England Journal of Medicine study concluded, "[w]e qualitatively agreed that the U.S. News rating system had the least chance of misclassifying hospital performance. There was considerable agreement in overall grade assignments among the six individuals who performed the ratings."[13] As one of the most highly

[13] *Id.*

regarded peer-reviewed publications in the world, the New England Journal of Medicine study affirms the credibility and significance of U.S. News rankings.

37. In January 2021, the Journal of General Internal Medicine published an article entitled "Revisiting US News & World Report's Hospital Rankings—Moving Beyond Mortality to Metrics that Improve Care", written by respected physicians at Brigham and Women's Hospital, Harvard Medical School, and Johns Hopkins Medicine.[14] The authors concluded: "[U.S. News] rankings have a powerful ability to provide useful information about where patients should seek care at a specialty and overall hospital level. Similarly, they can motivate hospitals to provide patient-centered care. We applaud [U.S. News'] efforts to help patients make informed decisions, and we hope that these rankings will evolve to be as reliable and valuable as possible to patients and providers."[15]

38. U.S. News' hospital rankings has garnered additional acclaim from countless other publications. USA Today, for instance, published an article on July 27, 2021 emphasizing U.S. News' inclusion of a health equity analysis in its 2022

[14] Mallika L. Mendu, et al., *Revisiting US News & World Report's Hospital Rankings—Moving Beyond Mortality To Metrics That Improve Care*, J. OF GENERAL INTERNAL MED. 36(1):209-210, July 7, 2020, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7858726/pdf/11606_2020_Article_6002.pdf (last visited Jan. 23, 2024).

[15] *Id.*

Best Hospitals rankings.[16] This health equity analysis identified that "racial and ethnic minorities were underrepresented among patients in roughly 4 out of 5 hospitals in the country," highlighting the importance for hospitals to be more cognizant of these issues when administering healthcare to their local populations.

39. On July 12, 2023, USA Today published a news article entitled "Hospital Rankings Are Far From Perfect. But Experts Say Patients Still Need Them."[17] In that article, an expert on quality care and patient safety noted generally with respect to hospital rankings: "The industry doesn't put out anything more accurate and doesn't put out anything more useful or more timely."[18] The article indicated that "[t]he annual ratings also create health competition where hospitals vie for patients by devoting resources to hospital quality and safety, which leads to better care and health outcomes."[19]

40. U.S. News believes that its methodology relies on "world-class data and technology," and it has ample justification for its opinion. The rankings rely on the

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[16] *See* Adrianna Rodriguez, *US Hospitals Struggle To Reduce Health Disparities: Minority Patients Underrepresented In 4 Of 5 Hospitals*, USA TODAY, July 27, 2021, *available at* https://www.usatoday.com/story/news/health/2021/07/27/us-news-best-hospital-ranking-includes-first-health-equity-analysis/8090005002/ (last visited Jan. 23, 2024).

[17] Adrianna Rodriguez, *Hospital Rankings Are Far From Perfect. But Experts Say Patients Still Need Them*, USA TODAY, July 12, 2023, *available at* https://www.usatoday.com/story/news/health/2023/07/12/why-patients-need-us-hospital-health-rankings/70396794007/ (last visited Jan. 23, 2024).

[18] *Id.*

[19] *Id.*

Medicare fee-for-service data set, a widely employed data set by academic researchers and various stakeholders. Notably, the rankings incorporate sophisticated technologies from third-party software companies which are highly regarded in the industry. These robust data sources and advanced technological tools contribute to the reliability and accuracy of U.S. News' hospital rankings. As discussed above, U.S. News continually enhances its data points through ongoing improvements and refinements. As the New England Journal of Medicine notes in its study, U.S. News notably improved its rating system by "weighting volume for proportion of Medicare Advantage patients, improving outcome measures with exclusion of external transfers, and adding risk adjustment for sociodemographic factors."[20]

41. These are only a handful of the reputable publications that support U.S. News' beliefs and assertions about the quality and value of its hospital rankings. Undoubtedly, there are other publications that may disagree. Views on both sides are subjective opinions entitled to the fullest First Amendment protections. It is not up to any government to choose between any competing opinions or to respond to one view or the other with adverse governmental action or inquiry.

[20] Karl Y. Bilimoria, et al., *supra* n.12.

III. DEFENDANT'S UNCONSTITUTIONAL INQUIRY INTO U.S. NEWS' PROTECTED SPEECH

42. On June 20, 2023, the City Attorney sent U.S. News a demand letter seeking information regarding the Best Hospital rankings. *See* Exhibit A. On its face, the City Attorney's letter evinced viewpoint-based criticisms of the U.S. News' rankings and methodologies. Among other things, the letter expressed "significant concerns about the rankings of hospitals," stated that the rankings "suffer from poor and opaque methodology," questioned the "reliability of the rankings," and suggested (falsely) that "USNWR's ranking methodology is seriously flawed." Exhibit A at 1-2. From there, the letter called out specific aspects of the determinations that U.S. News has made in producing its rankings—such as the selection of "Honor Roll" hospitals, the relative emphasis on cystic fibrosis versus sickle cell disease, the alleged "fail[ure] to incorporate indicators of health equity," an "undue emphasis on mortality," and U.S. News' regard for "subjective opinion surveys." *Id*. at 2-3. The letter was a textbook example of content and viewpoint-based discrimination by a government entity.

43. The City Attorney's letter sought to couch its criticisms of the content of U.S. News rankings with specious allegations of potential wrongdoing. For example, the City Attorney alleged a potential violation of California Business and Professions Code section 17508 because U.S. News "advertises itself as an

authoritative resource in comparing hospitals overall, regionally, and with respect to specialties, procedures, and specific medical conditions." *Id*. at 1-2. Specifically, the City Attorney challenged U.S. News' portrayal of itself as the "global authority in hospital rankings," and the assertions that its rankings are "authoritative," based on "world-class data and technology," and to aid patients and families in "find[ing] the best healthcare," making "data-informed decisions," and identifying "sources of skilled inpatient care." *Id*. According to the City Attorney, U.S. News may not offer favorable opinions of itself without providing "all evidence of the facts on which" it bases such opinions. *Id*. If this were the law, every news organization and business in America would face potential legal peril anytime it speaks highly of itself. But the First Amendment says otherwise.

44. Moreover, the statute that the City Attorney relied on is inapplicable because these statements are not "advertising claim[s]." Under Section 17508, an actionable statement must meet a three-part test to fall within the purview of California's False Advertising Law (Cal. Bus. & Prof. Code § 17500 et seq.): "(1) a commercial speaker, (2) an intended commercial audience, and (3) representations of fact of a commercial nature." *Bernardo v. Planned Parenthood Fed'n of Am*., 115 Cal. App. 4th 322, 347–48 (2004) (citing *Kasky v. Nike, Inc*., 27 Cal. 4th 939, 964 (2002)). The City Attorney's letter did not identify any commercial statements of fact. In *Bernardo*, the court held that mere statements of opinion on Planned

Parenthood's website were not actionable as commercial advertisements. *Bernardo*, 115 Cal. App. 4th at 348; *see also Nike*, 27 Cal. 4th at 967 (holding that the False Advertising Law and Unfair Competition Law "do not suppress points of view but instead suppress false and misleading ***statements of fact***") (emphasis added).

45. The same no less follows for U.S. News' descriptions of its rankings. These statements about U.S. News' journalism are subjective opinion, not commercial statements of fact, and they accordingly are not actionable as a matter of law. In any event, these statements are amply validated by the views of independent third-party publications and industry observers, as detailed above.

46. The City Attorney also baselessly alleged that U.S. News had violated 16 C.F.R. § 255.5, a provision of FTC's Guides Concerning the Use of Endorsements and Testimonials in Advertising ("Guides"), by failing to disclose payments from its ranked hospitals for badge licensing, data subscriptions, and advertising on U.S. News' website and guidebook. According to the letter, the Guides apply to U.S. News because it is an "endorser" under Section 255.0 of the Guides, and the hospital payments "might materially affect the weight or credibility of the endorsement," thereby triggering disclosure obligations under Section 255.5. Exhibit A at 3.

47. The City Attorney's FTC allegations are misplaced for four reasons.

48. First, U.S. News' rankings of hospitals are not "endorsements" or "testimonials" in advertising as defined by the Guides. In its notice of adoption in 2009, the FTC stated:

> In general, under usual circumstances, the Commission **does not consider reviews published in traditional media** (i.e., where a newspaper, magazine, or television or radio station **with independent editorial responsibility** assigns an employee to review various products or services as part of his or her official duties, and then publishes those reviews) **to be sponsored advertising messages**. Accordingly, **such reviews are not "endorsements"** within the meaning of the Guides. Under these circumstances, the Commission believes, knowing whether the media entity that published the review paid for the item in question would not affect the weight consumers give to the reviewer's statements.[21]

49. The Commission further clarified that its view regarding endorsements "would be the same . . . **for an Internet News website with independent editorial responsibility**, rather than a traditional brick-and-mortar periodical."[22] In other words, there is no endorsement so long as the news media is editorially independent in its reporting, rather than reporting on behalf of advertisers or their agent.[23] U.S. News is a media company with independent editorial responsibility; its editorial content is assigned to staff who review and report hospitals as their official duties

[21] Guides Concerning the Use of Endorsements and Testimonials in Advertising, 74 Fed. Reg. 53136 (Oct. 15, 2009) (revising 16 C.F.R. § 255) (emphasis added).

[22] *Id.* at 53136 n.101.

[23] *Id.* at 53136.

and have no involvement in the company's advertising content.[24] The Guides simply do not apply.

50. Second, even if the Guides did apply—and they do not—no disclosure would be warranted under the circumstances. Section 255.5 requires disclosure of a *material* connection between the endorser and the seller of the advertised product. A "material connection" is a relationship that "might materially affect the weight or credibility of the endorsement, and that connection is not reasonably expected by the audience…."[25] The Commission acknowledges that "some connections may be immaterial because they are too insignificant to affect the weight or credibility given to endorsements."[26] Here, there is absolutely no connection between the rankings a hospital may receive and their decision to license a badge or purchase advertising in U.S. News.

51. Third, the Guides are merely "administrative interpretations" of the Federal Trade Commission Act ("FTCA"); they do not constitute binding law subject to enforcement by the City Attorney's Office.[27] Section 255.0, the "purpose and definitions" section of the Guides, provides that the Guides "address the application

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[24] U.S. News, *U.S. News & World Report Editorial Guidelines, available* at https://www.usnews.com/about-us/editorial-guidelines (last visited Jan. 23, 2024).

[25] 16 C.F.R. § 255.5(a).

[26] *Id.*

[27] 16 C.F.R. § 255.0(a).

of section 5 of the FTC Act, 15 U.S.C. 45, to the use of endorsements and testimonials in advertising" and "provide the basis for voluntary compliance with the law by advertisers and endorsers."[28] Thus, although "[p]ractices inconsistent with these Guides may result in corrective action by the [Federal Trade] Commission," they do not automatically constitute violations of the law or the FTCA.[29] Moreover, only the FTC – not the City Attorney nor anyone else – can enforce the FTCA. "It is well-established that there is no private right of action for violation of the FTCA; only the Federal Trade Commission has standing to enforce it. "[30]

52. Finally, and contrary to the implications in the City Attorney's letter, commercial relationships with hospitals have no influence whatsoever in determining a hospital's position in U.S. News' rankings or even whether a hospital is ranked at all. The independence of editorial determinations—free from business

[28] *Id.*

[29] *Id.*; *see also F.T.C. v. Garvey*, 383 F.3d 891, 903 (9th Cir. 2004); *BHRS Grp., LLC v. Brio Water Tech., Inc.*, 2020 WL 9422352, at *9 (C.D. Cal. Dec. 14, 2020); *Christensen v. Harris County*, 529 U.S. 576, 587 (2000) (holding mere interpretations expressed in policy statements, agency manuals, and enforcement guidelines lack the force of law).

[30] *Kerr v. Am. Home Mortg. Servicing, Inc.*, 2010 WL 3743879, at *3 (S.D. Cal. Sept. 23, 2010); *see also Carlson v. Coca-Cola Co.*, 483 F.2d 279 (9th Cir. 1973) ("The protection against unfair trade practices afforded by the Act vests initial remedial power solely in the Federal Trade Commission").

considerations—is a bedrock journalistic principle, to which U.S. News proudly adheres.

53. On June 20, 2023, shortly after sending the letter to U.S. News, the City Attorney expounded, via his personal Twitter account, his disagreement with the content of U.S. News' hospital rankings:

> Today, my Office sent a letter seeking information on @usnews hospital rankings, which have come under scrutiny for ***questionable methodology, bias & undisclosed financial relationships*** with highly ranked hospitals. Consumers use these rankings to make consequential health care decisions, and yet there is little understanding that ***the rankings are fraught*** & that U.S. News has financial relationships with the hospitals it ranks. The ***hospital rankings appear to be biased towards providing treatment for wealthy, white patients, to the detriment of poorer, sicker, or more diverse populations***. This creates perverse incentives that may be warping our healthcare system. Hospitals are essentially "treating to the test" by investing in specialties that rack up the most points rather than in primary care or other worthy specialties.[31]

54. In parallel, the City Attorney announced the letter from the official City Attorney account and on the City Attorney's website, again repeating his baseless allegation that U.S. News' rankings have a "questionable methodology."[32] Six days later, the City Attorney tweeted, again from his personal account, that, "[f]ollowing

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[31] David Chiu, Tweet Message, X.com, *available at* https://x.com/DavidChiu/status/1671246558967500800?s=20 (last visited Jan. 23, 2024) (emphasis added).

[32] San Francisco City Attorney, Tweet Message (June 20, 2023), *available at* https://twitter.com/SFCityAttorney/status/1671245937271005184 (last visited Jan. 23, 2024); San Francisco City Attorney, *U.S. News & World Report Faces Legal Scrutiny Over Dubious Hospital Rankings*, June 20, 2023, *available at* https://www.sfcityattorney.org/2023/06/20/u-s-news-world-report-faces-legal-scrutiny-over-dubious-hospital-rankings/ (last visited Jan. 23, 2024).

the letter my office sent US News last week, the University of Pennsylvania Health System has joined other hospitals in withdrawing from US News & World Report's dubious hospital rankings."[33] The City Attorney was evidently pleased that his use of his official government powers had caused damage to U.S. News' business and reputation. Moreover, the City Attorney's public statements—issued before U.S. News even had an opportunity to respond—demonstrate that the City Attorney had prejudged the issues at the very outset of the investigation.

55. U.S. News met with the City Attorney's Office on July 11, 2023 to discuss the June 20 Letter. During the meeting, the City Attorney's Office confirmed that it believes that U.S. News should be using a different methodology or factors in its hospital rankings. The City Attorney's Office also expressed the view that it was well within the City Attorney's power to question U.S. News over which factors and criteria it should be considering when conducting its hospital rankings. Indeed, a review of many of the informational requests in Attachment A to the letter confirms that the City Attorney is claiming power to second-guess and reshape U.S. News' chosen approach to its rankings. Ex. A at 5-7. For example, the letter asks whether U.S. News has considered and declined modifications and changes to certain ranking

[33] David Chiu, Tweet Message, X.com, *available at* https://x.com/DavidChiu/status/1673456048882208769 (last visited Jan. 23, 2024).

methodologies. *Id*. It asks what plans U.S. News has to address what the City Attorney perceives as disparities in weighting certain diseases. *Id*. It asks what plans does U.S. News have to expand and develop its measures of health equity. *Id*. The Attachment also advocates for certain changes in the methodology raised by critics of U.S. News' rankings under the heading "Data Limitations." *Id*.

56. The City Attorney's questions about the propriety of U.S. News' methodology and the factors considered are misplaced and cannot be justified under the guise of regulating mere advertising. As the Ninth Circuit Court of Appeals recently explained with respect to ratings systems, "there is an inherently subjective element in deciding which scientific and objective criteria to consider. For example, publications that rank colleges or law schools purportedly rely on objective criteria (*e.g.*, acceptance rates, test scores, class size, endowment), but selecting those criteria involves subjective decision-making." *ARIIX, LLC v. NutriSearch Corp.*, 985 F.3d 1107, 1121 (9th Cir. 2021). That healthcare professionals disagree regarding the best data and modeling methods to be used in hospital rankings only underlines the subjectivity at work here. No such opinion can be properly labeled or regulated as though it is false advertising.

57. On July 19, 2023, U.S. News sent a response to the City Attorney's letter. A copy of this letter is attached as Exhibit B. U.S. News alerted the City Attorney that his inquiries infringed upon U.S. News' rights under the First

Amendment and the Liberty of Speech Clause, but nonetheless provided a thoroughgoing response to the baseless allegations in the letter.

58. On January 9, 2024, the City Attorney sent a response letter to U.S. News in which he simply reiterated his view that U.S. News must disclose the methodology behind its hospital rankings, must substantiate its statements about the quality and value of these rankings, and must disclose additional financial information relating to the rankings. A copy of this letter is attached as Exhibit C. The letter attached two Subpoenas: one seeking documents relating to the hospital rankings, and another containing interrogatories relating to the rankings. A copy of the Subpoenas are attached as Exhibits D and E.

59. The interrogatory Subpoena contains fourteen interrogatories relating to U.S. News hospital rankings. Each of these interrogatories infringes upon U.S. News' First Amendment rights as a private speaker and a media enterprise. For example, the Subpoena includes no less than seven interrogatories second-guessing and challenging U.S. News' protected speech regarding its rankings:

> Describe USNWR's basis for stating that its Best Hospitals rankings are "[h]ow to find the best medical care in 2023," as stated on the following webpage: https://health.usnews.com/best-hospitals.
>
> Describe USNWR's basis for according 19 times greater weight to cystic fibrosis treatment than to sickle cell disease treatment in the Children's Hospital rankings;
>
> Describe how, if at all, USNWR has incorporated primary and preventive care in each annual version of the Best Hospitals rankings;

> Describe USNWR's basis for not including measures of health equity in its rankings of adult Hospitals;
>
> Describe how USNWR has adjusted the Medicare fee-for-service dataset to reflect actual patient populations in each annual version of its Best Hospitals rankings;
>
> Describe USNWR's basis for believing that Medicare outcomes information from at least 18 months ago accurately reflects current Hospital outcomes;
>
> Describe USNWR's basis for using opinion surveys as the exclusive method for ranking Hospitals in ophthalmology, psychiatry, and rheumatology and for incorporating opinion surveys into other specialties ranked by USNWR.

Ex. D at 3-4 (Rog. Nos. 7-13).

60. The interrogatory Subpoena also demands that U.S. News identify *all* hospitals who have paid U.S. News for *any* purpose, including badge licensing, data, advertising, and promotion. Ex. D at 3 (Rog Nos. 1-6). These requests reflect an improper governmental attempt to intimidate and dissuade U.S. News and the hospitals from entering into commercial relationships with each other, harming U.S. News' business, simply because the City Attorney disagrees with U.S. News' hospital rankings and methodology.

61. The document Subpoena is similarly intrusive, demanding U.S. News' agreements with any hospitals identified in the interrogatories, as well as its contracts with certain partners who have assisted U.S. News in creating the Best Hospitals rankings. Ex. E at 3.

62. The City Attorney's attempt to seek confidential, unpublished information and documents regarding U.S. News' business relationships, and to imply through government coercion and investigation that these relationships are in any way improper, appear designed to cause economic and reputational harm to U.S. News. The City Attorney has previously touted the harm that his investigation has caused to U.S. News, and there is substantial risk that enforcement of the Subpoenas will intimidate hospitals and other entities from advertising with U.S. News or providing data to assist its rankings.

63. If U.S. News were to surrender to the City Attorney's demands and alter its hospital rankings to align with his preferences, the implications would be severe. The City Attorney, for example, has accused U.S. News of placing "an undue emphasis on mortality"[34], and has subpoenaed information regarding the use of "opinion surveys" in its rankings.[35] But readers are entitled to make their own decisions about these factors when making personal health care decisions. To be sure, the City Attorney may have his own differing opinions from U.S. News' editors, to which he is entitled. What he should not be doing is trying to dictate and second-guess the editorial judgments of U.S. News. No government official should be imposing his personal views at the expense of a free press.

[34] Ex. A at 2.
[35] Ex. D (Rog. No. 13).

IV. THE CITY ATTORNEY'S ENFORCEMENT ACTION APPEARS MOTIVATED BY THE AGENDA OF U.S. NEWS' CRITICS, AS OPPOSED TO ANY PURPORTED GOVERNMENT INTEREST

64. The City Attorney's brazen efforts to trample the First Amendment rights of U.S. News are facially unlawful. Concerns are further compounded, however, by indications that the City Attorney is furthering the personal agenda of critics of U.S. News and its rankings, as opposed to any genuine governmental interest.

65. The original June 20, 2023, letter from the City Attorney instructed U.S. News to "direct any questions and provide the requested documentation, information, and confirmation by July 5, 2023, to Chief of Complex and Affirmative Litigation Sara Eisenberg." Ex. A at 3-4. U.S. News met with Ms. Eisenberg and others on July 11, 2023 to discuss its concerns with the letter, and U.S. News sent its response letter to Ms. Eisenberg. Ex. B at 1. And when the City Attorney's Office sent its Subpoenas on January 9, 2024, Ms. Eisenberg was once again copied. Ex. F (Jan. 9, 2024 Email from City Attorney's Office). Ms. Eisenberg, meanwhile, is the City Attorney's liaison with Yale Law School's San Francisco Affirmative Litigation Project ("SFALP"), a partnership between Yale Law School and the San Francisco City Attorney's Office. SFALP is led by Dean Heather Gerken of Yale Law School,

an outspoken critic of U.S. News' rankings, who works closely with Ms. Eisenberg to oversee this partnership.[36]

66. Dean Gerken founded SFALP in 2006[37] and "is one of the few Deans in the country to run a clinic."[38] The program "pairs Yale Law students with lawyers from the San Francisco City Attorney's Office to conceive, develop, and litigate cutting-edge public interest cases."[39] The SFALP website explains how the Yale program works closely and fluidly with the City Attorney's Office:

> Imagine a public interest law firm with significant resources, outstanding attorneys, and standing to bring suits that most public interest groups cannot bring without costly class-action litigation. With a long history of engaging in civil law enforcement and public policy litigation, the San Francisco City Attorney's Office deploys top-flight lawyers to pursue affirmative litigation on behalf of the people of San Francisco and California. Yale students work with deputy city attorneys on the Affirmative Litigation Task Force through every stage of the litigation process, from brainstorming possible suits to filing complaints to motions practice.[40]

67. SFALP "embodies the vision of Dean Heather K. Gerken[.]"[41] A litigation guide co-published by the City Attorney and SFALP encourages "city,

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[36] Yale Law School, *San Francisco Affirmative Litigation Project, About Us*, *available at* https://law.yale.edu/sfalp/about-us (last visited Jan. 23, 2024).

[37] *Id.*

[38] Yale Law School, *Heather Gerken*, *available at* https://law.yale.edu/heather-gerken (last visited Jan. 23, 2024).

[39] Yale Law School, *San Francisco Affirmative Litigation Project*, *available at* https://law.yale.edu/sfalp (last visited Jan. 23, 2024).

[40] Yale Law School, *San Francisco Affirmative Litigation Project, SF City Attorney's Office available at* https://law.yale.edu/sfalp/sf-city-attorneys-office (last visited Jan. 23, 2024).

[41] Yale Law School, SFALP, The Opioid Epidemic, And Public Interest at SFALP, the Opioid Epidemic, and Public Impact | Yale Law School (last visited Jan. 23, 2024).

county, and district attorney's offices to embrace a broader sense of mission: as not only the attorney for the city or county as an institution, but also as the attorney representing the interests of its residents."[42]

68. The litigation guide also discusses strategies for using consumer protection laws to achieve public interest goals: "What makes consumer protection law especially valuable for impact litigation is its breadth and versatility. When local law offices take full advantage of consumer protection law, they can engage in a wide range of public interest litigation. They may engage in prototypical consumer protection cases—combatting deceptive sales tactics, false advertising, or unfair banking and lending practices. But, local law offices can also use consumer protection laws to protect residents from business practices that cause other types of widespread harm or threaten residents' well-being."[43]

69. For the past few years, while partnering with the City Attorney through SFALP, Dean Gerken has become one of the leading critics of the rankings of U.S. News. In 2022, Yale became the first top 14 law school to decline to participate in U.S. News' ranking survey of law schools.[44] In her public notice describing the

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[42] *Local Action, National Impact: A Practical Guide To Affirmative Litigation For Local Governments*, at 4, *available at* A-Practical-Guide-to-Affirmative-Litigation-FINAL-4.13.19-1.pdf (sfcityattorney.org) (last visited Jan. 23, 2024).

[43] *Id.* at 16.

[44] *See* Ines Chomnalez, *Yale Law School withdraws from "perverse" U.S. News rankings,* Yale News, Nov. 16, 2022 at https://yaledailynews.com/blog/2022/11/16/yale-law-school-withdraws-from-perverse-u-s-news-rankings/ (last visited Jan. 23, 2024).

reasons for Yale Law School's decision, Dean Gerken criticized the rankings as "profoundly flawed" and lacking a "sound methodology," and stated that "the rankings process is undermining the core commitments of the legal profession."[45] Dean Gerken went further, stating that the "ill-conceived system" of U.S. News' rankings "applies a misguided formula that discourages law schools from doing what is best for legal education," uses a "backward approach" to student debt loads, and provides "inadequate weight" to how much financial aid a law school provides to its students.[46] Even after U.S. News met with over 100 law school administrators and made changes to the law school ranking criteria,[47] Dean Gerken continued to criticize U.S. News, telling press outlets that Yale Law School had "cemented our decision to stop participating in the rankings."[48] Such comments notwithstanding,

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[45] *Dean Gerken: Why Yale Law School Is Leaving the U.S. News & World Report Rankings*, Yale Law School, Nov. 16, 2022 at https://law.yale.edu/yls-today/news/dean-gerken-why-yale-law-school-leaving-us-news-world-report-rankings (last visited Jan. 23, 2024).

[46] *Id.*

[47] Robert Morse and Stephanie Salmon, *Plans for Publication of the 2023-2024 Best Law Schools*, U.S. News, Jan. 2, 2023 *available at* https://www.usnews.com/education/blogs/college-rankings-blog/articles/2023-01-02/plans-for-publication-of-the-2023-2024-best-law-schools (last visited Jan. 23, 2024).

[48] Ines Chomnalez, *U.S. News Rankings To Be Modified, Yale Law Doubles Down On Withdrawal*, Yale Daily News, Jan. 23, 2023, *available at* https://yaledailynews.com/blog/2023/01/23/u-s-news-rankings-to-be-modified-yale-law-doubles-down-on-withdrawal/ (last visited Jan. 23, 2024); *see also Education Secretary Cardona And Expert Panelists Discuss A Future Beyond Rankings*, Yale Law School, March 2, 2023, available at https://law.yale.edu/yls-today/news/education-secretary-cardona-and-expert-panelists-discuss-future-beyond-rankings (last visited Jan. 23, 2024);

U.S. News published its news law school rankings in 2023, and Dean Gerken continued her criticism of U.S. News.[49]

70. The City Attorney's letter mirrors Dean Gerken's criticism of U.S. News' rankings. Both the City Attorney and Dean Gerken have criticized U.S. News' "methodology" and the "weight" U.S. News gives to certain factors,[50] both have called the rankings "flawed,"[51] both claimed that U.S. News' rankings cause "harm,"[52] and both have accused U.S. News of "disincentiviz[ing]" programs that assist individuals with fewer means.[53]

71. It is striking that U.S. News' primary contact with the City Attorney's Office has been Ms. Eisenberg, Dean Gerken's liaison and partner in the SFALP program. While U.S. News respects Dean Gerken's First Amendment right to express her views publicly, such criticism belongs in the public square, where it may (or may not) persuade—it should not be weaponized by the City Attorney's Office

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[49] *See, e.g.*, Jack Stripling, *Yale Sparked A U.S. News Rankings Revolt. Here's What Happened Next*, Washington Post, Dec. 4, 2023, available at https://www.washingtonpost.com/education/2023/12/04/us-news-law-school-revolt-yale (last visited Jan. 23, 2024).

[50] Compare *Dean Gerken*, *supra* n. 45 *with* Ex. A (June 20, 2023 Letter from the City Attorney); *see also* Ex. D (Interrogatory Subpoena) at 3-4.

[51] Compare *Dean Gerken*, *supra* n. 45 *with* Ex. A (June 20, 2023 Letter from the City Attorney).

[52] Compare *Dean Gerken*, *supra* n. 45 *with* City Attorney of San Francisco, *U.S. News & World Report Faces Legal Scrutiny Over Dubious Hospital Rankings* (June 20, 2023), *supra* n. 32.

[53] Compare *Dean Gerken*, *supra* n. 45 *with* Ex. A (June 20, 2023 Letter from the City Attorney).

to launch unconstitutional enforcement actions. This Court should not allow any private party, in any way, to co-opt government so as to impose a personal viewpoint on others. By adopting Dean Gerken's preferred viewpoint as though it deserves the force of law, the City Attorney's Subpoenas are overstepping beyond the bounds of proper law enforcement and unconstitutionally attempting to chill and penalize a disfavored viewpoint. Despite the prevalence of countless media publications that perform various types of rankings, including of hospitals, U.S. News is unaware of the City Attorney investigating any of these other publications.

Count I – First Amendment (Chilling Freedom of Speech and of the Press) (Pursuant to 28 U.S.C. §§ 2201, 2202; 42 U.S.C. §§ 1983, 1988)

72. Plaintiffs repeat, re-allege, and incorporate the allegations in paragraphs 1–71 of this Complaint as though fully set forth herein.

73. The First Amendment to the United States Constitution applies to California by virtue of the Fourteenth Amendment.

74. The First Amendment provides that "Congress shall make no law ... abridging the freedom of speech, or of the press ...." U.S. Const. amend. I.

75. "The First Amendment, applied to states through the Fourteenth Amendment, prohibits laws abridging the freedom of speech." *Animal Legal Def. Fund v. Wasden*, 878 F.3d 1184, 1193 (9th Cir. 2018) (internal quotation omitted).

76. "Under that Clause, a government, including a municipal government vested with state authority, has no power to restrict expression because of its message, its ideas, its subject matter, or its content." *Reed v. Town of Gilbert, Ariz.*, 576 U.S. 155, 163 (2015) (internal quotation omitted).

77. "That the First Amendment speaks separately of freedom of speech and freedom of the press is no constitutional accident, but an acknowledgment of the critical role played by the press in American society." *Houchins v. KQED, Inc.*, 438 U.S. 1, 17 (1978) (Stewart, J., concurring).

78. The Liberty of Speech Clause in the California Constitution similarly provides that "[e]very person may freely speak, write and publish his or her sentiments on all subjects" and "[a] law may not restrain or abridge liberty of speech or press." Cal. Const. art. I, § 2. The California Supreme Court has held that the Liberty of Speech Clause "grants broader rights to free expression than does the First Amendment to the United States Constitution." *Fashion Valley Mall, LLC v. Nat'l Lab. Rels. Bd.*, 42 Cal. 4th 850, 857 (2007).

79. In violation of 42 U.S.C. § 1983, the Subpoenas, on pain of criminal penalties for lack of compliance, infringes the rights of U.S. News that are secured by the First and Fourteenth Amendments and the Liberty of Speech Clause, irreparably injuring U.S. News.

80. Here, the City Attorney is investigating and threatening enforcement against U.S. News because the City Attorney faults the content of U.S. News' speech in the form of its journalism and methodologies. Such adverse government action implicates both the First Amendment and the Liberty of Speech Clause, and is subject to strict scrutiny. "The level of scrutiny with which [a court reviews] a restriction of free speech activity depends upon whether it is a content-neutral regulation of the time, place, or manner of speech or restricts speech based upon its content." *Fashion Valley Mall, LLC*, 42 Cal. 4th at 865 (2007). A law is content-based "if the main purpose in enacting it was to suppress or exalt speech of a certain content, or it differentiates based on the content of speech on its face." *Matter of Search Warrant for [redacted].com*, 248 F. Supp. 3d 970, 981 (C.D. Cal. 2017) (search warrant notice preclusion order was a content-based restriction subject to strict scrutiny) (internal quotation omitted).

81. A law that is intended to regulate speech based on its particular content or viewpoint is "presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests." *Reed*, 576 U.S. at 163. "It is rare that a regulation restricting speech because of its content will ever be permissible." *United States v. Playboy Ent. Grp., Inc.*, 529 U.S. 803, 818 (2000).

82. The City Attorney's June 20, 2023 letter and subsequent Subpoenas demonstrate content- and viewpoint-based criticisms and intrusions against the U.S. News' journalism and methodologies. Among other things, the June 20 letter expresses "significant concerns about the rankings of hospitals," states that the rankings "suffer from poor and opaque methodology," questions the "reliability of the rankings," and suggests (falsely) that "[U.S. News'] ranking methodology is seriously flawed." Ex. A at 1-2. The Subpoenas go a step further, threatening potential contempt for noncompliance if U.S. News does not answer the City Attorney's hostile, invasive questions and produce requested documents behind the hospital rankings. Exs. D, E.

83. U.S. News' rankings and opinions are its own. They are not published by the City Attorney, nor does U.S. News need the City Attorney's approval and endorsement in order to publish them as it does. By the same token, the City Attorney lacks legal charter to translate any potential disagreement with U.S. News' rankings into a burdensome, intrusive investigation, let alone an enforcement action, at U.S. News' grave expense. *See, e.g., Giebel v. Sylvester*, 244 F.3d 1182, 1188–89 (9th Cir. 2001) (attempts to single out and silence a particular speaker amount to impermissible viewpoint discrimination); *Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Bos.*, 515 U.S. 557, 581 (1995) ("Disapproval of a private speaker's statement does not legitimize use of the [state's] power to compel the speaker to alter

the message by including one more acceptable to others."); *Miami Herald Pub. Co. v. Tornillo*, 418 U.S. 241, 256 (1974) (requirement that newspaper "publish that which reason tells them should not be published is unconstitutional") (internal quotation omitted); *Nat'l Rifle Ass'n of Am. v. City of Los Angeles*, 441 F. Supp. 3d 915, 930 n.3 (C.D. Cal. 2019) (enjoining, as an impermissible content-based restriction on speech, city ordinance that "collaterally attack[s] disfavored speech via a disclosure requirement").

84. The City Attorney's demand gives U.S. News two choices. Either it must provide the requested documents and information, which will chill and burden its protected speech. Or else it must bear the penalties of noncompliance with the Subpoenas. So whichever way U.S. News goes with this Hobson's choice, it stands to lose First Amendment freedoms—and thus suffer irreparable injury—unless this Court issues declaratory and injunctive relief.

Count II – California Reporters' Shield Law
(Pursuant to California Constitution [Art. I. § 2(b)]
and Cal. Evid. Code § 1070)

85. Plaintiffs repeat, re-allege, and incorporate the allegations in paragraphs 1–84 of this Complaint as though fully set forth herein.

86. The City Attorney's demands for information regarding U.S. News' rankings, methodologies, and sources of funding also conflict with the Reporters'

Shield Law, embodied in the California Constitution (art. I, § 2, subd. (b)) and the California Evidence Code (Cal. Evid. Code § 1070).

87. "A publisher, editor, reporter, or other person connected with or employed upon a newspaper ... shall not be adjudged in contempt ... for refusing to disclose the source of any information . . . or for refusing to disclose any unpublished information[.]" Cal. Const. art. I, § 2(b); *see also* Cal. Evid. Code § 1070 (same).

88. The Shield Law safeguards the press against intrusive inquiries into unpublished information, confidential sources, and methodologies. "Since contempt is generally the only effective remedy against a nonparty witness, the California enactments . . . grant such witnesses virtually absolute protection against compelled disclosure." *New York Times Co. v. Superior Ct.*, 51 Cal. 3d 453, 461 (1990).

89. This solicitude for the press is also reflected in United States Department of Justice policy guidelines, which circumscribe the instances in which the DOJ will subpoena the press:

> (1) A free and independent press is vital to the functioning of our democracy. Because freedom of the press can be no broader than the freedom of members of the news media to investigate and report the news, the Department's policy is intended to provide protection to members of the news media from certain law enforcement tools and actions, whether criminal or civil, that might unreasonably impair newsgathering. . . .
>
> (2) The Department recognizes the important national interest in protecting journalists from compelled disclosure of information revealing their sources, sources they need to apprise the American people of the workings of their Government. For this reason, with the exception of certain circumstances set out in this section, the

> Department of Justice will not use compulsory legal process for the purpose of obtaining information from or records of members of the news media acting within the scope of newsgathering.

28 C.F.R. § 50.10.

90. The City Attorney's letter does not compare favorably. It disregards the critical role that a longstanding news organization such as U.S. News plays in the public sphere. The City Attorney has combined legal threats with burdensome demands for confidential information as part of a concerted effort to censor and revise U.S. News' rankings so that they better align with the City Attorney's viewpoint. Its Subpoenas should be enjoined as violations of California's Reporters' Shield Law.

Prayer for Relief

Wherefore, U.S. News respectfully requests that judgment be entered in its favor and against the City Attorney as follows:

1. A declaration that the Subpoenas violate the First Amendment (as incorporated by the Fourteenth Amendment), the Liberty of Speech Clause of the California Constitution, and California's Reporters' Shield Law, and is therefore null and void in its entirety;

2. An order temporarily restraining the City Attorney from enforcing the Subpoenas until a hearing can be held on a preliminary injunction, unless the City

Attorney agrees his office will not enforce the Subpoenas before such a hearing may be held;

3. An order preliminarily enjoining the City Attorney from enforcing the Subpoenas during the pendency of the litigation, unless the City Attorney agrees his office will not enforce the Subpoenas before this Court can issue a decision on the merits;

4. An order permanently enjoining the City Attorney from enforcing the Subpoenas;

5. An award to U.S. News of its reasonable attorneys' fees and costs; and

6. A grant to U.S. News of such additional or different relief as the Court deems just and proper.

Jury Demand

Plaintiff U.S. News hereby demands a trial by jury as to all issues so triable in this case.

Dated: January 23, 2024

Respectfully submitted,

QUINN EMANUEL URQUHART & SULLIVAN LLP

By /s/ *John Potter*
John Potter

Attorneys for Plaintiff
U.S. News & World Report, L.P.

EXHIBIT A

CITY AND COUNTY OF SAN FRANCISCO

DAVID CHIU
City Attorney

OFFICE OF THE CITY ATTORNEY

Telephone: (415) 554-4700
Email: cityattorney@sfcityatty.org

June 20, 2023

VIA FIRST CLASS MAIL, EMAIL, AND PERSONAL SERVICE ON REGISTERED AGENT

Eric Gertler
Executive Chairman and Chief Executive Officer
U.S. News & World Report, L.P.
120 Fifth Avenue
New York, NY 10011
egertler@usnews.com

Re: Concerns with U.S. News & World Report Hospital Rankings

Dear Mr. Gertler:

I write to express significant concerns about the rankings of hospitals produced by U.S. News & World Report ("USNWR"). USNWR holds itself out as an expert on ranking hospitals, but medical experts have recently raised concerns that USNWR's rankings suffer from poor and opaque methodology, mislead those using the rankings, and create perverse incentives for hospitals nationwide. Indeed, one hospital network recently withdrew from USNWR citing many of these issues. In addition, USNWR fails to disclose the fact that it receives payments from at least some of the ranked hospitals, which deprives the public of key information in considering the reliability of the rankings. In the recent wake of public scrutiny of USNWR's ranking methodology of other institutions, which has led law schools, medical schools, and colleges to withdraw from its rankings, the public deserves answers to many questions.

As the City Attorney for the City and County of San Francisco, I have a duty to ensure San Franciscans and Californians have access to accurate information as they make critical healthcare decisions. To that end, my Office asks for three things. First, we request evidence supporting USNWR's assertions about the quality of its hospital rankings. Second, we seek specific information about the basis for the hospital rankings methodology and apparent deficiencies in the rankings. And third, we demand that USNWR take immediate steps to comply with Federal Trade Commission ("FTC") regulations requiring that it prominently disclose the hospitals from which it receives payments.

A. Request for Substantiation of Advertising (Cal. Bus. & Prof. Code § 17508)

USNWR advertises itself as an authoritative resource in comparing hospitals overall, regionally, and with respect to specialties, procedures, and specific medical conditions. USNWR refers to its Best Hospitals rankings as "authoritative" and describes itself as "the global authority in hospital rankings." It claims that it has been "[h]elping patients and families find the best healthcare for more than 30 years." It describes its hospital rankings as "a tool that can help these patients find sources of skilled inpatient care." And it encourages patients to follow its rankings even over physician referrals, claiming "[t]he hospital the doctor suggested for you might be right for you – but maybe not." Across its rankings, including rankings of hospitals, USNWR says it uses "world-class data and technology to publish independent reporting, rankings, journalism and advice."

These statements constitute advertising claims supporting the asserted usefulness of USNWR's hospital rankings. And they appear to be working across USNWR's rankings. In 2013, USNWR had 20 million viewers a month and made 20% of its revenue from online searches for rankings. Today, USNWR claims more than 40 million users visit its site every month "during moments when they are most in need of expert advice and motivated to act on that advice directly on our platforms."

Despite USNWR's apparent success at driving website views, these representations of authority, expertise, and rigor appear to lack support and may therefore violate California law. Under California Business and Professions Code section 17508, any city attorney may request substantiation of any advertising claims made to California consumers that purport to be based on "any fact" or on "factual, objective, or clinical evidence." Under this authority, and in light of the concerns expressed by medical experts and discussed below, I request that USNWR provide all evidence of the facts on which USNWR bases its claims that:

- USNWR is "the global authority in hospital rankings";
- USNWR's hospital rankings are "authoritative" and based on "world-class data and technology"; and
- USNWR's hospital rankings help patients and families "find the best healthcare," "make data-informed decisions," and "find sources of skilled inpatient care."

B. Request for Information About USNWR's Hospital Ranking Methodology

Recent medical research—some of it behind paywalls and therefore inaccessible to those using USNWR's rankings—has highlighted many ways USNWR's hospital rankings may mislead the public and create perverse incentives for hospitals. That research, described in Attachment A and cited in the endnotes, indicates that USNWR's ranking methodology is seriously flawed for many reasons, including:

- USNWR's Honor Roll rankings—which purports to rank the 20 "best" overall hospitals in the country simply by adding up points USNWR assigns based on its own rankings for certain specialties, procedures, and conditions—warps the provision of healthcare by incentivizing hospitals to invest disproportionately in areas where they will accrue the most points over other specialties or primary and preventive care. This also results in skewing additional research funding and consumer demand towards already prosperous specialty hospitals and away from community and safety net hospitals at a time when 20% of California hospitals are at risk of closure.
- The USNWR ranking methodology creates and perpetuates health equity disparities. For example, USNWR's rankings award far more points in the children's hospital rankings for treatment of cystic fibrosis ("CF") than sickle cell disease ("SCD") when the former disease disproportionately affects White children and the latter disproportionately affects African American children. USNWR fails to incorporate indicators of health equity into its adult rankings in any way.
- The USNWR rankings rely on imprecise data, fail to consider the cost of care, and place an undue emphasis on mortality, penalizing and disincentivizing providing care for sicker and poorer patients.
- Three of the USNWR specialty rankings are based entirely on subjective opinion surveys. For others, opinion surveys form a significant portion of the rankings. Reliance on these surveys introduces a range of potential biases. Doctors have incentives to vote for their own hospitals and against competitors in the same region or specialty. And doctors from

a different region or specialty generally lack direct experience or knowledge of hospitals where they have not practiced, meaning their opinions could be based on speculation or lobbying by well-resourced institutions.

The questions in Attachment A relate to these and other issues that have been raised with USNWR's rankings. For example, why does the method USNWR uses to generate the Honor Roll result in an "authoritative" overall ranking of hospitals? What plans does USNWR have to expand and develop its measures of health equity? And how has USNWR checked that the variables it uses accurately reflect a hospital's quality of care? To facilitate my Office's investigation into the veracity of USNWR's representations regarding the quality of its rankings, I request that USNWR respond to each of the questions set forth in Attachment A to this letter.

C. Requirement for Disclosure of Funding Relationships

USNWR appears to violate FTC regulations by not disclosing payments that it receives from the hospitals it ranks. USNWR receives money from ranked hospitals in at least three ways: (1) through fees to license USNWR's Best Hospitals badges (or Best Children's Hospitals badges) to display on ranked hospitals' advertising; (2) through subscriptions to the Hospital Data Insights database to get "instant access to the unpublished granular data that underpins the U.S. News Best Hospitals Rankings & Ratings"; and (3) through payments for online and print advertisements on USNWR's website and its Best Hospitals Guidebook. These revenue streams are significant for USNWR. Although many hospitals refuse to state how much they pay to use a "Best Hospital" badge on their website or advertising because of a "contractual agreement," Children's Mercy Hospital in Kansas acknowledged that it paid $42,000 to use the logo for one year in 2014. And the Washington Post reported that in 2013, licensing of the "best of" badges accounted for 15% of the company's total revenue. But USNWR does not disclose with its rankings—or seemingly anywhere else—which hospitals in its rankings have paid for badges or hospital data.

The FTC has interpreted the Federal Trade Commission Act to require disclosure of material connections between an endorser and the subject of the endorsement. 16 C.F.R. §§ 255.0, 255.5. The broad definition of an "endorser" includes USNWR. 16 C.F.R. § 255.0. USNWR's many statements encouraging reliance on its hospital rankings (and the "Best Hospital" name) confirm that the rankings are endorsements (notwithstanding a perplexing disclaimer on the website that "USNews.com does not recommend or endorse . . . information found on USNews.com"). The relevant test for whether disclosure is required is whether "there exists a connection between the endorser and the seller of the advertised product that might materially affect the weight or credibility of the endorsement (i.e., the connection is not reasonably expected by the audience)." 16 C.F.R. § 255.5. The responsibility to disclose material connections falls on the endorser along with the recipient of the endorsement. *See, e.g.*, 16 C.F.R. § 255.0, Example 8. Because the public would not reasonably expect that some ranked hospitals are paying USNWR for badge licensing, data subscriptions, or advertising, USNWR is required to disclose prominently that it receives these payments.

To facilitate my Office's investigation into the scope of your violations, please provide us with a list of the hospitals that have paid USNWR or its agents as well as the number of website impressions for the hospital rankings in the last four years. In addition, please confirm that USNWR has added the required disclosures to prevent further violations of the law.

* * *

Thank you in advance for your responses about substantiation of USNWR's representations, answers to the questions in Attachment A, and prompt disclosure of hospital

funding relationships. Please direct any questions and provide the requested documentation, information, and confirmation by July 5, 2023, to Chief of Complex and Affirmative Litigation Sara Eisenberg, Office of the City Attorney, 1390 Market Street, 7th Floor, San Francisco, CA 94102 (sara.eisenberg@sfcityatty.org; 415-554-3874).

Very truly yours,

David Chiu

DAVID CHIU
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Attachment A

1. *Questionable Honor Roll method.* To produce its Honor Roll ranking of top hospitals, USNWR simply adds up points it assigns to hospitals based on its own rankings for specialties, procedures, and conditions. For example, the hospitals USNWR ranks as #1 in Orthopedics and in Neurology & Neurosurgery each receive 25 points, the #1-ranked hospital in Psychiatry receives 10 points, and all 4,127 hospitals rated as "High Performing" in Diabetes receive 12 points. This methodology rewards hospitals' investment in the specialties and procedures that will accumulate them the greatest number of points to the exclusion of other specialties and procedures and critical primary care.[i]

   a. Why does the method USNWR uses to generate the Honor Roll result in an "authoritative" overall ranking of hospitals?
   b. How did USNWR set this method?
   c. Who at USNWR or RTI International, which we understand partners with USNWR for the hospital rankings, was involved in setting this method?
   d. How has USNWR modified or changed this method in the last ten years?
   e. Has USNWR considered other modifications or changes, whether suggested by hospitals or otherwise, and declined to make those changes? If so, why?

2. *Disparate weighting of childhood diseases.* USNWR's methodology gives disproportionate weight to cystic fibrosis ("CF") treatment versus sickle cell disease ("SCD") treatment in the children's hospital rankings. CF "affects 1 in 3,500 White Americans and 1 in 17,000 Black Americans. In contrast, SCD affects 1 in 365 Black or African American newborns and is rare enough among White newborns that the Centers for Disease Control and Prevention does not report a prevalence rate."[ii] USNWR awards 19 points specifically for CF care but only one point for SCD care.[iii]

   a. Why does USNWR accord much greater weight to CF treatment than SCD treatment in ranking children's hospitals?
   b. What plans does USNWR have to address this disparity?

3. *Lack of inclusion of health equity in adult rankings.* USNWR in recent years has begun including indicators of health equity on the pages for each hospital but has not incorporated that information into its adult rankings in any way.[iv]

   a. When will USNWR include health equity in its adult rankings?
   b. What plans does USNWR have to expand and develop its measures of health equity?

4. *Data limitations.* In 2021, a group of surgeons concluded that variability in USNWR's ear, nose, and throat surgery specialty rankings reflected "unreliable or imprecise methods rather than factual changes in program quality."[v] The surgeons observed that the modeling method used by USNWR "favors higher-volume programs, as their outcomes are presumed to be more reliable" but that this method for modeling may not be appropriate particularly in specialties involving large year-to-year variation in numbers of patients. Furthermore, USNWR's rankings and ratings are based in large part on data from a limited subset of patients—inpatient fee-for-service Medicare patients that constituted only 11% of surgical cases in the authors' department—rather than outpatient, Medicaid, Medicare managed care, or privately insured patients. And USNWR attributes mortality to a particular specialty based on Medicare Severity Diagnosis Related Groups ("MS-DRG") data designed as a hierarchy of diseases, not a classification of medical specialties or hospital departments. Based on these concerns, the authors explained the "rankings may have the unintended effect of promoting a system of coding

gamesmanship to minimize falsely attributed negative outcomes and of penalizing hospitals that treat the sickest of the sick."[vi] Another group of scholars used a representative clinical data set to examine mortality and other outcomes in the USNWR specialty of gastroenterology and gastrointestinal surgery and strikingly found no statistically significant differences in in-hospital mortality or serious morbidity between USNWR-ranked and unranked hospital programs.[vii] Meanwhile, the researchers found statistically significant increased costs and lengths of hospitalization at USNWR-ranked hospitals compared to unranked hospitals.[viii]

a. Are hospitals that treat poorer and sicker patients disadvantaged in the USNWR rankings based on the issues discussed above?
b. How, if at all, does USNWR ensure data submitted by hospitals is accurate?
c. How does USNWR adjust the Medicare fee-for-service dataset to reflect actual patient populations?
d. We understand that the Medicare fee-for-service dataset is shrinking as the Medicare managed care dataset expands but that USNWR does not use the latter, growing dataset. What further adjustments, if any, does USNWR make to account for the shrinking size of the Medicare dataset on which it relies?

5. *Inaccurate proxies for important measures of care.* The Nurse Staffing Index ("NSI") indicator that USNWR uses to reflect nurse staffing may not "be a valid measure of actual nurse staffing or hospital quality."[ix] For example, it was inversely related to actual nurse staffing in two of three states considered in a recent study. The NSI "appeared to be more of a reflection of hospital structural factors (larger teaching hospitals) than an actual indicator of clinical quality."[x]

a. What steps has USNWR taken to ensure that NSI reflects actual nurse staffing?
b. How has USNWR checked that other variables it uses accurately reflect a hospital's quality of care?

6. *Continued role of peer opinion surveys.* In ophthalmology, psychiatry, and rheumatology, USNWR's rankings are based entirely on opinion surveys.[xi] For other specialties, opinion surveys form a significant portion of the rankings.[xii] This creates an incentive for doctors "to vote for their own hospitals and to avoid voting for competitor hospitals in the same region."[xiii] Meanwhile, specialist physicians from outside of a specific region likely do not have direct experience with patient care at hospitals where they have not practiced, making them poor judges of care.[xiv] We also understand that USNWR distributes its surveys only to doctors who use the physician network Doximity, in which USNWR appears to hold an equity interest. With its equity holding, USNWR makes money based on doctors using Doximity, raising concerns about self-dealing.

a. Why are opinion surveys the appropriate exclusive method for ranking hospitals in ophthalmology, psychiatry, and rheumatology?
b. For other specialties, why is the quality of care best measured by giving significant weight to opinion surveys?
c. What is the response rate for each survey?
d. What steps is USNWR taking to reduce the effects on the rankings of inherent biases physicians have in ranking competitor institutions?
e. Does USNWR distribute its opinion surveys exclusively or significantly to physicians enrolled in Doximity? Why does USNWR distribute its surveys in the way it does?
f. Does USNWR hold an equity interest in Doximity?

g. Does USNWR disclose anywhere that its survey data is based on responses from physicians enrolled in a company in which USNWR has or had an equity interest?

7. *Focus on specialty care.* USNWR explains in a methods document that "[i]t is essential to use the Best Hospital rankings for their intended purpose—to help consumers determine, together in consultation with their physicians, which hospitals provide the best care for the most serious or complicated medical conditions and procedures"—reflecting a focus on specialty care.[xv] Yet the Best Hospitals main page does not appear to reflect this limitation in the purpose of the rankings. Nor do even the procedure/condition ratings meaningfully account for the importance of high-quality primary and preventive care.

a. How, if at all, does USNWR incorporate quality primary and preventive care in its rankings?

b. Why are these critical services not given greater weight?

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[i] *See* Curtis Warfield, Eugene Lin & Malika L. Mendu, *Nephrology and the US News and World Report Hospital-Based Specialty Rankings*, 5 Kidney Med., Mar. 3, 2023, at 1 (raising concerns with the elimination of nephrology as a specialty in the USNWR rankings).

[ii] Madeline Wozniak & Chinenyenwa Mpamaugo, *It's Time for US Hospitals to Withdraw from the US News and World Report Rankings*, Health Affs. Forefront (Mar. 17, 2023).

[iii] Murrey G. Olmsted, et al., *Methodology: U.S. News & World Report Best Children's Hospitals 2022-23* at 86, 121, RTI Int'l (July 21, 2022), https://health.usnews.com/media/best-hospitals/BCH_Methodology_2022-23.pdf.

[iv] Tavia Binger & Ben Harder, *Health Equity and Measures Hospital Rankings—Reply*, 329 JAMA 764 (2023); Ge Bai, Kosali Simon & Peter Cram, *Health Equity Measures and Hospital Rankings*, 329 JAMA 764 (2023); Tavia Binger, Harold Chen & Ben Harder, *Hospital Rankings and Health Equity*, 328 JAMA 1805 (2022); Mary I. O'Connor, *Equity360: Gender, Race, and Ethnicity: Our "Best Hospitals" Rank Poorly in Health Equity*, 479 Clinical Orthopaedics & Related Research 2366 (2021).

[v] Kaitlyn M. Frazier, Christine G. Gourin & C. Matthew Stewart, *Fatally Flawed—Making Sense of US News & World Report Mortality Scores*, 147 JAMA Otolaryngology – Head & Neck Surg. 317, 317 (2021).

[vi] *Id.* at 318.

[vii] Sahil Gambhir, et al., *Association of US News &World Report Top Ranking for Gastroenterology and Gastrointestinal Operation with Patient Outcomes in Abdominal Procedures*, 154 JAMA Surgery 861 (2019).

[viii] *Id.*; *see also* Oliver K. Jawitz et al., *Comparing Consumer-Directed Hospital Rankings with STS Adult Cardiac Surgery Database Outcomes*, 115 Annals of Thoracic Surgery 533 (2023) (finding no agreement between the USNWR's hospital rankings of hospitals and the risk-adjusted morbidity and mortality for cardiac surgery).

[ix] Ryan Merkow, et al., *Correlation of the US News and World Report–Calculated Nurse Staffing Index with Actual Hospital-Reported Nurse Staffing*, 37 J. Nursing Care Quality 195, 198 (2022).

[x] *Id.* at 197.

[xi] Andrew A. Nierenberg, *US News and World Report Rankings of Psychiatry: A Misleading, Anachronistic Exercise*, 53 Psychiatric Annals 54 (2023) (raising concerns about this use of opinion surveys).

[xii] *See also* Santino Cua, et al., *Reputation and the Best Hospital Rankings: What Does It Really Mean?*, 32 Am. J. Medical Quality 632 (2007) (finding that "reputation has a more significant influence on total *U.S. News* score than its objective counterparts" and that methods changes "failed to lessen reputation's impact").

[xiii] Timothy J. Daskivich & Bruce L. Gewertz, *Campaign Reform for US News and World Report Rankings*, 158 JAMA Surg. 114, 114 (2023).

[xiv] *Id.* at 115.

[xv] Olmsted et al., *Methodology U.S. News & World Report 2022-23 Best Hospitals: Specialty Rankings*, *supra* at 1.

EXHIBIT B

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July 19, 2023

Via E-Mail and Federal Express

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Re: Response to Concerns with U.S. News & World Report Hospital Rankings

Dear Ms. Eisenberg:

On behalf of U.S. News & World Report ("U.S. News"), we respectfully submit this response to City Attorney Chiu's letter, dated June 20, 2023, sent to U.S. News' Executive Chairman and CEO. Without waiving any journalistic, constitutional or evidentiary privileges, U.S. News is providing this response in an effort to address the points raised in the letter. As noted in our meeting on July 11, 2023, after you have the opportunity to review and consider this submission, we will make ourselves available to continue the dialogue between your office and ours.

As a 90-year old journalistic institution with a reputation for fact-based and data-driven reporting coupled with a history of transparency, U.S. News has developed a rigorous and well-respected hospital ranking methodology which provides important information to healthcare consumers. This ranking methodology is published annually, communicated widely, and is wholly transparent. U.S. News takes its mission to help consumers make the best healthcare decisions very seriously and it operates its business with the highest of journalistic standards.

The City Attorney's suggestion that U.S. News is engaged in false advertising and has failed to comply with FTC disclosure guidelines is quite troubling and, with all due respect, these concerns are misplaced. As discussed further below, the assertion that U.S. News' hospital rankings and its characterizations of them constitute "advertisements" is an affront to the extensive independent research, analysis and journalistic effort which goes into the creation of these rigorous rankings year after year. These independent reviews and research not only provide a valuable resource to the public but are entitled to the full protection of the First Amendment as non-commercial speech.

For all of these reasons, the allegations suggested by the City Attorney's letter are contrary to the advertising laws, the FTC guidelines, and the Constitutions of the United States and California.

Background of U.S. News and its Methodology for Hospital Rankings

U.S. News has been ranking hospitals for 34 years. The methodology used to produce each year's Best Hospitals rankings is updated and refined on an annual basis by a team of professionals and journalists led by a Managing Editor and a Senior Health Data Scientist. Each member of the team works full time on the hospital rankings. Team members are not involved in sales of any products or services and revenue considerations do not impact the rankings in any way.

In formulating its rankings, U.S. News has contracted for nearly 20 years with RTI International, a not-for-profit research organization based in North Carolina, to support the publication of Best Hospitals: Specialty Rankings and Best Children's Hospitals. Additionally, U.S. News has from time to time contracted with other professional organizations to support its analytical work.

The process the team uses to iteratively refine its methodology is designed to be responsive to stakeholder feedback, advances in measurement science, and changes in how healthcare is delivered to beneficiaries of America's largest insurance plan, Medicare. This process requires both judgment and scientific methods.

Stakeholder feedback is an essential component of the journalistic process, and the team obtains feedback via multiple modalities, including: (1) working groups comprising medical experts; (2) U.S. News-convened focus groups of healthcare consumers; (3) U.S. News-initiated interaction with medical researchers and study authors; (4) memoranda and letters submitted by specialty societies, hospital consortia, researchers, clinicians, patients, patient advocate groups, hospital and health system administrators, and other stakeholders; (5) professional meetings at which U.S. News staff present and receive feedback; (6) U.S. News hosted conferences and webinars in which U.S. News staff present and receive feedback; and (7) other miscellaneous communications with stakeholders.

Advances in measurement science are identified by: (1) reading peer-reviewed studies published in relevant scientific journals, such as the Journal of the American Medical Association, Health Affairs, and Health Services Research; (2) speaking with and corresponding with researchers about the methods they have used in such studies; and (3) conducting independent scientific research.

Relevant changes in healthcare delivery are identified by studying policy announcements issued by the Centers for Medicare and Medicaid Services, as well as studying data, whether issued by other groups or derived internally, to understand changing trends in how and where diseases are treated and how treatments are documented in the data sets available for our analysis.

The U.S. News team and its contractor RTI International curate the feedback received and identify candidate methodology changes that, in its members' opinions, are likely to improve the precision with which the methodology identifies high-performing hospitals.

U.S. News publishes, along with the actual rankings, reports which describe in detail the methodologies underlying each of its Best Hospital rankings for that year. The reports describe the changes that have been made from the prior year's methodology, the data that is collected/used, the weighting of the data and criteria, the expert opinion component to the rankings, and even methodological improvements that are being considered for future years. These detailed methodology reports are available for download so that anyone can see the methodology used for a particular ranking in any particular year. We encourage your office to download and review the 275 pages of methodology documentation referenced in Footnote 6.

Request for Substantiation of Advertising (Cal. Bus. & Prof. Code § 17508)

The City Attorney requests substantiation for certain so-called "advertising" statements made by U.S. News about its rankings and the data it relies upon. Specifically, the City Attorney challenges U.S. News' portrayal of itself as the "global authority in hospital rankings," and the assertions that its rankings are "authoritative," based on "world-class data and technology," and aid patients and families in "finding the best healthcare," making "data-informed decisions," and identifying "sources of skilled inpatient care." These statements about U.S. News's journalism are legally deemed to be subjective opinion and while they therefore are not actionable as a matter of law, they are, in any event, amply supported as discussed in further detail below.

As an initial matter, Cal. Bus. & Prof. Code § 17508, which the City Attorney relies on, is inapplicable because these statements are not "advertising claim[s]." Under Section 17508, an actionable statement must meet a three-part test to fall within the purview of California's False Advertising Law (Cal. Bus. & Prof. Code § 17500 et seq.): "(1) a commercial speaker, (2) an intended commercial audience, and (3) representations of fact of a commercial nature."[1] The City Attorney's letter does not identify any commercial statements of fact. In *Bernardo*, the court held that mere statements of opinion on Planned Parenthood's website were not actionable as commercial advertisements.[2] The same no less follows for U.S. News' descriptions of its rankings.

Nevertheless, numerous third party evaluations by experts in the industry support U.S. News' views about the value of its hospital rankings. Most notably, in 2019, health researchers writing in the New England Journal of Medicine, renowned as one of the world's most respected and influential medical journals, bestowed upon U.S. News the highest grade among the hospital rankings they evaluated. The researchers conducted a comprehensive study to evaluate various hospital ranking systems, including CMS Hospital Compare Overall Star Ratings, Healthgrades Top Hospitals, Leapfrog Safety Grade and Top Hospitals, and U.S. News. The study involved a group of experienced methodologists, consisting of physician scientists with expertise in healthcare quality measurement from academic centers and the private sector. The study established six major criteria for assessing these rating systems: Potential for Misclassification of

[1] *Bernardo v. Planned Parenthood Fed'n of Am*., 115 Cal. App. 4th 322, 347–48 (2004) (citing *Kasky v. Nike, Inc*., 27 Cal. 4th 939, 964 (2002).

[2] *Bernardo*, 115 Cal. App. 4th at 348; *see also Nike*, 27 Cal. 4th at 967 (holding that the False Advertising Law and Unfair Competition Law "do not suppress points of view but instead suppress false and misleading ***statements of fact***.") (emphasis added).

Hospital Performance, Importance/Impact, Scientific Acceptability, Iterative Improvement, Transparency, and Usability. The assessment aimed to identify strengths, weaknesses, and opportunities for improvement in the rating systems. This rigorous study spanned several months and aimed to provide users with valuable insights into the different rating systems, ultimately aiding in their decision-making process.

U.S. News emerged as the top-ranking system. It surpassed even the U.S. Government's own rating system, Hospital Compare. The New England Journal of Medicine study concluded, "We qualitatively agreed that the U.S. News rating system had the least chance of misclassifying hospital performance. There was considerable agreement in overall grade assignments among the six individuals who performed the ratings." As one of the most highly regarded peer-reviewed publications in the world, the New England Journal of Medicine study affirms the credibility and significance of U.S. News rankings.

In January 2021, the Journal of General Internal Medicine published an article entitled "Revisiting US News & World Report's Hospital Rankings—Moving Beyond Mortality to Metrics that Improve Care", written by respected physicians at Brigham and Women's Hospital, Harvard Medical School, and Johns Hopkins Medicine. The authors concluded: "*USNWR* rankings have a powerful ability to provide useful information about where patients should seek care at a specialty and overall hospital level. Similarly, they can motivate hospitals to provide patient-centered care. We applaud *USNWR's* efforts to help patients make informed decisions, and we hope that these rankings will evolve to be as reliable and valuable as possible to patients and providers."

U.S. News' hospital rankings has garnered additional acclaim from countless other publications. USA Today, for instance, published an article on July 27, 2021 emphasizing U.S. News' inclusion of a health equity analysis in its 2022 Best Hospitals rankings.[3] This health equity analysis identified that "racial and ethnic minorities were underrepresented among patients in roughly 4 out of 5 hospitals in the country," highlighting the importance for hospitals to be more cognizant of these issues when administering health care to their local populations.

In fact, as recently as July 12, 2023, USA Today published a news article entitled "Hospital rankings are far from perfect. But experts say patients still need them."[4] In that article, an expert on quality care and patient safety noted generally with respect to hospital rankings: "The industry doesn't put out anything more accurate and doesn't put out anything more useful or more timely". Contrary to the City Attorney's letter suggesting that hospital rankings create perverse incentives, this article indicated that "[t]he annual ratings also create health competition where hospitals vie for patients by devoting resources to hospital quality and safety, which leads to better care and health outcomes."

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[3] *See* US News Best Hospital ranking includes first health equity analysis" located at https://www.usatoday.com/story/news/health/2021/07/27/us-news-best-hospital-ranking-includes-first-health-equity-analysis/8090005002/

[4] https://www.usatoday.com/story/news/health/2023/07/12/why-patients-need-us-hospital-health-rankings/70396794007/

These are only a handful of the reputable publications that support U.S. News' assertions about the quality and value of its hospital rankings. Undoubtedly, there are other publications the City Attorney could (and does) point to that do not share this same opinion. That fact alone confirms that these statements are subjective opinions and not subject to false advertising laws.

U.S. News' belief that its methodology relies on "world-class data and technology" is also amply justified. The rankings rely on the Medicare fee-for-service data set, a widely employed data set by academic researchers and various stakeholders. Notably, the rankings incorporate sophisticated technologies such as Stata, the 3M Health Information Systems Ambulatory Potential Preventable Complications software, and the Elixhauser Comorbidity Index, which are highly regarded in the industry. These robust data sources and advanced technological tools contribute to the reliability and accuracy of U.S. News' hospital rankings. As discussed above, U.S. News continually enhances its data points through ongoing improvements and refinements. As the New England Journal of Medicine notes in its study, U.S. News' notably improved its rating system by "eliminating all NHSN measures and most PSIs, weighting volume for proportion of Medicare Advantage patients, improving outcome measures with exclusion of external transfers, and adding risk adjustment for sociodemographic factors."

The City Attorney's letter asserts that U.S. News encourages patients to follow its rankings even over physician referrals, claiming "[t]he hospital the doctor suggested for you might be right for you – but maybe not." This assertion is a mischaracterization of U.S. News' messaging regarding its rankings. In multiple locations on its website explaining the rankings and how they should be used, U.S. News makes clear that "these ratings should be taken as a starting point. All care decisions should be made in conjunction with medical professionals."[5] The website also includes a prominently displayed disclaimer that underscores the informational nature of the content pertaining to doctors, hospitals, nursing homes, diets, and health products on USNews.com. The disclaimer emphasizes that this information should be used as a guide rather than the sole basis for decision-making. It further highlights the importance of seeking advice from medical professionals for specific health concerns.

Request for Information about U.S. News Hospital Ranking Methodology

The City Attorney's letter requests specific information about U.S. News' Hospital Ranking Methodology, claiming that "research" has suggested its methodology is flawed. Based on this faulty premise, the City Attorney proceeds to ask a number of questions about U.S. News' Hospital Ranking Methodology. Many of these questions can be answered by reference to the extremely detailed reports U.S. News publishes on its website describing the methodology in minute detail.[6] The report for the Best Hospitals: Specialty Rankings alone spans 166 pages. In addition, we have

[5] https://health.usNews.com/health-care/best-hospitals/articles/faq-how-and-why-we-rank-and-rate-hospitals

[6] https://health.usnews.com/media/best-hospitals/BH_Methodology_2022-23; https://health.usnews.com/media/best-hospitals/BHPC-Methodology-2022-2023; https://health.usnews.com/media/best-hospitals/Best-Hospitals-Health-Equity-2022-23.

provided above a detailed description of the process used by U.S. News in connection with preparing its hospital rankings.

During our meeting on July 11, 2023, we asked whether the City Attorney was aware that U.S. News publishes its detailed methodologies on its website for each hospital ranking every year, which your colleague acknowledged.

We also asked whether the City Attorney contends that statements in the methodology itself were false or misleading or rather, the City Attorney believes that U.S. News should be using a different methodology or factors in its hospital rankings. Your colleagues confirmed that it was the latter and expressed the view that it was well within the City Attorney's power to question U.S. News over which factors and criteria it should be considering when conducting its hospital rankings. Indeed, a review of many of the informational requests in Attachment A to the letter confirms this view. For example, the City Attorney asks whether U.S. News has considered and declined modifications and changes to certain ranking methodologies and why? What plans U.S. News has to address what the City Attorney perceives as disparities in weighting certain diseases? What plans does U.S. News have to expand and develop its measures of health equity? The Attachment also seems to be advocating for certain changes in the methodology raised by critics of U.S. News' rankings under the heading "Data Limitations".

The City Attorney's questions about the propriety of U.S. News' methodology and the factors considered are misplaced and cannot be justified under the guise of advertising laws. As the Ninth Circuit Court of Appeals recently explained with respect to ratings systems, "there is an inherently subjective element in deciding which scientific and objective criteria to consider. For example, publications that rank colleges or law schools purportedly rely on objective criteria (*e.g.*, acceptance rates, test scores, class size, endowment), but selecting those criteria involves subjective decision-making."[7] The fact that healthcare professionals disagree regarding the best data and modeling methods to be used in hospital rankings makes clear that these involve matters of subjective decision-making and not subject to false advertising laws.

Even more concerning, the City Attorney's requests threaten U.S. News' freedom of expression by intruding into and second-guessing the journalistic decision-making behind U.S. News' venerable hospital rankings. Underlying and animating the various requests are the City Attorney's stated differences of opinion with U.S. News' published rankings and methodologies. Numerous laws prohibit the government from regulating or influencing the free press and opinions thereof, including the (i) First Amendment to the United States Constitution; (ii) Article I, section 2(a) (the "Liberty of Speech Clause") of the California Constitution; and (iii) Article I, section 2(b) (the "Reporters' Shield Law") of the California Constitution. While U.S. News is willing to continue the dialogue with the City Attorney on these issues, any such conversation must respect the fundamental rights of the free press.

[7] *ARIIX, LLC v. NutriSearch Corp.*, 985 F.3d 1107, 1121 (9th Cir. 2021).

The City Attorney's Investigation Constitutes Viewpoint-Based Discrimination

The First Amendment provides that "Congress shall make no law ... abridging the freedom of speech, or of the press...."[8] "The First Amendment, applied to states through the Fourteenth Amendment, prohibits laws abridging the freedom of speech."[9] "Under that Clause, a government, including a municipal government vested with state authority, has no power to restrict expression because of its message, its ideas, its subject matter, or its content."[10] "That the First Amendment speaks separately of freedom of speech and freedom of the press is no constitutional accident, but an acknowledgment of the critical role played by the press in American society."[11]

The Liberty of Speech Clause in the California Constitution similarly provides that "[e]very person may freely speak, write and publish his or her sentiments on all subjects" and "[a] law may not restrain or abridge liberty of speech or press."[12] The California Supreme Court has held that the Liberty of Speech Clause "grants broader rights to free expression than does the First Amendment to the United States Constitution."[13]

Here, the City Attorney is investigating and threatening action against U.S. News because the City Attorney disagrees with U.S. News' rankings and methodology. Such adverse government action implicates both the First Amendment and the Liberty of Speech Clause, and would trigger strict scrutiny by any reviewing court. "The level of scrutiny with which [a court reviews] a restriction of free speech activity depends upon whether it is a content-neutral regulation of the time, place, or manner of speech or restricts speech based upon its content."[14] A law is content-based "if the main purpose in enacting it was to suppress or exalt speech of a certain content, or it differentiates based on the content of speech on its face."[15] A law that is intended to regulate speech based on its content or the speaker's viewpoint is "presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests."[16] "It is rare that a regulation restricting speech because of its content will ever be permissible."[17]

The City Attorney's letter evinces viewpoint-based criticisms of the U.S. News' rankings and methodologies. Among other things, the letter expresses "significant concerns about the rankings of hospitals," states that the rankings "suffer from poor and opaque methodology," questions the "reliability of the rankings," and suggests (falsely) that "USNWR's ranking methodology is

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[8] U.S. Const. amend. I.
[9] *Animal Legal Def. Fund v. Wasden*, 878 F.3d 1184, 1193 (9th Cir. 2018) (internal quotation omitted).
[10] *Reed v. Town of Gilbert, Ariz.*, 576 U.S. 155, 163 (2015).
[11] *Houchins v. KQED, Inc.*, 438 U.S. 1, 17 (1978) (Stewart, J., concurring).
[12] Cal. Const. art. I, § 2.
[13] *Fashion Valley Mall, LLC v. Nat'l Lab. Rels. Bd.*, 42 Cal. 4th 850, 857 (2007).
[14] *Id.*
[15] *Matter of Search Warrant for [redacted].com*, 248 F. Supp. 3d 970, 981 (C.D. Cal. 2017) (search warrant notice preclusion order was a content-based restriction subject to strict scrutiny).
[16] *Reed*, 576 U.S. at 163.
[17] *United States v. Playboy Ent. Grp., Inc.*, 529 U.S. 803, 818 (2000).

seriously flawed."[18] From there, the letter calls out specific aspects of the determinations that U.S. News has made in producing its rankings—such as the selection of "Honor Roll" hospitals, the relative emphasis on cystic fibrosis versus sickle cell disease, the alleged "fail[ure] to incorporate indicators of health equity," an "undue emphasis on mortality," and U.S. News' regard for "subjective opinion surveys."[19]

Of course, U.S. News' rankings and its process for producing them are its own journalistic product. They are not published by the City Attorney, nor does U.S. News need the City Attorney's approval and endorsement in order to publish them as it does. By the same token, the City Attorney lacks legal charter to translate any disagreement with U.S. News' rankings into a burdensome, intrusive investigation, let alone an enforcement action, at U.S. News' grave expense.[20] The chilling effects of the City Attorney's inquiry in this regard cannot be overstated.

No such government second-guessing or granular censorship by any jurisdiction is proper. In formulating and publishing its rankings, U.S. News is not seeking to please everyone, nor is it capable of pleasing everyone. Rather, U.S. News is doing what conscientious publications in its position have long done, consistent with fundamental journalistic protections that the First Amendment protects: U.S. News is committed to inform the public on matters of public concern by its best lights, even in the face of controversy and possible government pushback.

The City Attorney's Demands Conflict With California's Reporters' Shield Law

The City Attorney's demands for information regarding U.S. News' rankings, methodologies, and sources of funding also conflict with the Reporters' Shield Law, embodied in the California constitution (art. I, § 2, subd. (b)) and the California Evidence Code (Cal. Evid. Code § 1070). "A publisher, editor, reporter, or other person connected with or employed upon a newspaper ... shall not be adjudged in contempt ... for refusing to disclose the source of any information . . . or for refusing to disclose any unpublished information[.]"[21] The Shield Law safeguards the press against intrusive inquiries into confidential sources and methodologies. "Since contempt is

[18] June 20 Letter at 1-2.
[19] *Id.* at 2-3.
[20] *See, e.g., Giebel v. Sylvester*, 244 F.3d 1182, 1188–89 (9th Cir. 2001) (attempts to single out and silence a particular speaker amount to impermissible viewpoint discrimination); *Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Bos*., 515 U.S. 557, 581 (1995) ("Disapproval of a private speaker's statement does not legitimize use of the [state's] power to compel the speaker to alter the message by including one more acceptable to others."); *Miami Herald Pub. Co. v. Tornillo*, 418 U.S. 241, 256 (1974) (requirement that newspaper "publish that which reason tells them should not be published is unconstitutional"); *Nat'l Rifle Ass'n of Am. v. City of Los Angeles*, 441 F. Supp. 3d 915, 930 n.3 (C.D. Cal. 2019) (enjoining, as an impermissible content-based restriction on speech, city ordinance that "collaterally attack[s] disfavored speech via a disclosure requirement").
[21] Cal. Const. art. I, § 2(b); *see also* Cal. Evid. Code § 1070 (same).

generally the only effective remedy against a nonparty witness, the California enactments . . . grant such witnesses virtually absolute protection against compelled disclosure."[22]

This solicitude for the press is also reflected in the United States Department of Justice policy guidelines, which circumscribe the instances in which the DOJ will subpoena the press:

> (1) A free and independent press is vital to the functioning of our democracy. Because freedom of the press can be no broader than the freedom of members of the news media to investigate and report the news, the Department's policy is intended to provide protection to members of the news media from certain law enforcement tools and actions, whether criminal or civil, that might unreasonably impair newsgathering. . . .
>
> (2) The Department recognizes the important national interest in protecting journalists from compelled disclosure of information revealing their sources, sources they need to apprise the American people of the workings of their Government. For this reason, with the exception of certain circumstances set out in this section, the Department of Justice will not use compulsory legal process for the purpose of obtaining information from or records of members of the news media acting within the scope of newsgathering.[23]

The City Attorney's letter disregards the critical role that a longstanding news organization such as U.S. News plays in the public sphere. In the case of the hospital rankings, that role has included providing U.S. News' readers with healthcare information that would be difficult if not impossible for them to find on their own. The City Attorney has combined legal threats with burdensome demands for privileged information as part of a concerted effort to revise U.S. News' rankings and bring them into line with the City Attorney's viewpoint. The City Attorney's letter does not square with freedom of speech and of the press, and with settled laws protecting same. While U.S. News will not compromise the constitutional rights that are at stake here and expressly reserves them all, we are willing to continue to engage in good faith discussions with your office consistent with U.S. News' legal rights and protections.

Inapplicability of the FTC Guidelines on Disclosure of Funding Relationships

The City Attorney's letter also claims that U.S. News appears to violate 16 C.F.R. § 255.5, a provision of FTC's Guides Concerning the Use of Endorsements and Testimonials in Advertising ("Guides"), by failing to disclose payments from its ranked hospitals for badge licensing, data subscriptions, and advertising on U.S. News' website and guidebook.[24] According to the letter, the Guides apply to U.S. News because it is an "endorser" under Section 255.0 of the Guides, and the hospital payments "might materially affect the weight or credibility of the endorsement,"

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[22] *New York Times Co. v. Superior Ct.*, 51 Cal. 3d 453, 461 (1990).
[23] 28 C.F.R. § 50.10.
[24] Although the FTC recently revised these Endorsement Guides on June 29, 2023, none of the revisions change the analysis contained herein.

thereby triggering disclosure obligations under Section 255.5. The City Attorney's concerns are misplaced for four reasons.

First, U.S. News' rankings of hospitals are not "endorsements" or "testimonials" in advertising as defined by the Guides. In its notice of adoption in 2009, the FTC stated:

> In general, under usual circumstances, the Commission **does not consider reviews published in traditional media** (i.e., where a Newspaper, magazine, or television or radio station **with independent editorial responsibility** assigns an employee to review various products or services as part of his or her official duties, and then publishes those reviews) **to be sponsored advertising messages**. Accordingly, **such reviews are not "endorsements"** within the meaning of the Guides. Under these circumstances, the Commission believes, knowing whether the media entity that published the review paid for the item in question would not affect the weight consumers give to the reviewer's statements.[25]

The Commission further clarified in a footnote that its view regarding endorsements "would be the same . . . **for an Internet News website with independent editorial responsibility**, rather than a traditional brick-and-mortar periodical."[26] In other words, there is no endorsement if the News media is editorially independent in its reporting, rather than reporting on behalf of advertisers or their agent.[27] U.S. News is a media company with independent editorial responsibility; its editorial content is assigned to staff who review and report hospitals as their official duties and have no involvement in the company's advertising content.[28] The Guides simply do not apply.

Second, even if the Guides did apply— and they do not – no disclosure would be warranted under the circumstances. Section 255.5 requires disclosure of a *material* connection between the endorser and the seller of the advertised product. A "material connection" is a relationship that "might materially affect the weight or credibility of the endorsement (i.e., the connection is not reasonably expected by the audience)."[29] The Commission acknowledges that "some connections may be immaterial because they are too insignificant to affect the weight or credibility given to endorsements."[30] Here, there is absolutely no connection between the rankings a hospital may receive and their decision to license a badge or purchase advertising in U.S. News.

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[25] Federal Register, Vol. 74, No. 198, at 53136, (https://www.federalregister.gov/documents/2009/10/15/E9-24646/guides-concerning-the-use-of-endorsements-and-testimonials-in-advertising) (emphasis added).
[26] *Id.* at 53136 n. 101.
[27] *Id.* at 53136.
[28] U.S. News Editorial Guidelines (https://www.usNews.com/about-us/editorial-guidelines).
[29] 16 C.F.R. § 255.5.
[30] Federal Register, Vol. 74, No. 198, at 44294, (https://www.federalregister.gov/documents/2009/10/15/E9-24646/guides-concerning-the-use-of-endorsements-and-testimonials-in-advertising).

Third, the Guides are merely "administrative interpretations" of the Federal Trade Commission Act ("FTCA"); they do not constitute binding law subject to enforcement by the City Attorney's Office.[31] Section 255.0, the "purpose and definitions" section of the Guides, provides that the Guides "address the application of Section 5 of the FTC Act (15 U.S.C. 45) to the use of endorsements and testimonials in advertising" and "provide the basis for voluntary compliance with the law by advertisers and endorsers."[32] Thus, although "[p]ractices inconsistent with these Guides may result in corrective action by the [Federal Trade] Commission," they do not automatically constitute violations of the law or the FTCA.[33] Moreover, only the FTC – not the City Attorney nor anyone else – can enforce the FTCA. "It is well-established that there is no private right of action for violation of the FTCA; only the Federal Trade Commission has standing to enforce it."[34]

Finally, and contrary to the implications in the City Attorney's letter, commercial relationships with hospitals have no influence whatsoever in determining a hospital's position in the rankings or even whether a hospital is ranked at all. The independence of editorial determinations – free from business considerations -- is a bedrock journalistic principle, to which U.S. News proudly adheres.

Conclusion

U.S. News stands behind its hospital rankings as a valuable and reliable resource to consumers of health care services. Others may share a different opinion, as is their right. But a difference in opinion does not give rise to a false advertising claim, nor does it justify a government inquiry into the journalistic and editorial decision-making of the media.

U.S. News hopes that this letter will put the City Attorney's stated concerns to rest. However, as we indicated during our meeting, we remain willing to engage in good faith discussions with your office consistent with U.S. News' rights and protections under the law.

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[31] 16 C.F.R. § 255.0.

[32] *Id.* (emphasis added).

[33] *Id.*; *F.T.C. v. Garvey*, 383 F.3d 891, 903 (9th Cir. 2004); *BHRS Grp., LLC v. Brio Water Tech., Inc*., No. 22CV07652JWHJCX, 2020 WL 9422352, at *9 (C.D. Cal. Dec. 14, 2020); *Christensen v. Harris County*, 529 U.S. 576, 587 (2000) (holding that mere interpretations expressed in policy statements, agency manuals, and enforcement guidelines, lack the force of law).

[34] *Kerr v. Am. Home Mortg. Servicing, Inc*., No. 10-CV-1612 BEN AJB, 2010 WL 3743879, at *3 (S.D. Cal. Sept. 23, 2010); *Carlson v. Coca-Cola Co.*, 483 F.2d 279 (9th Cir. 1973) ("The protection against unfair trade practices afforded by the Act vests initial remedial power solely in the Federal Trade Commission").

We look forward to continuing this dialogue with your office to the extent necessary.

Sincerely,

John Potter

cc: Michael E. Williams
Alexander Holtzman

EXHIBIT C

CITY AND COUNTY OF SAN FRANCISCO
DAVID CHIU
City Attorney

OFFICE OF THE CITY ATTORNEY
ALEXANDER J. HOLTZMAN
Deputy City Attorney

Direct Dial: (415) 554-3999
Email: alexander.holtzman@sfcityatty.org

January 9, 2024

VIA FIRST CLASS MAIL AND EMAIL

John Potter
Quinn Emanuel Urquhart & Sullivan LLP
50 California St., 22nd Floor
San Francisco, California 94111
johnpotter@quinnemanuel.com

Re: Investigation of U.S. News & World Report Hospital Ranking Advertising Representations and Hospital Payments

Dear Mr. Potter:

I write in response to your July 14, 2023 letter sent on behalf of U.S. News & World Report ("USNWR"). We are disappointed that USNWR has failed to meaningfully address the San Francisco City Attorney's Office's reasonable concerns about its hospital rankings and has refused to commit to providing transparency regarding its financial relationships with ranked hospitals.

Rather than engage with our Office, USNWR fails to provide *any* information responsive to the reasonable concerns raised in the City Attorney's letter. Similarly, USNWR has failed to provide any of the requested information about the hospitals that have paid USNWR, and appears unwilling to disclose information about these payments as required by the Federal Trade Commission Act as interpreted by the Federal Trade Commission's regulations.

Instead, USNWR points to third party sources in an attempt to show that its advertising practices are lawful. Yet, the few articles referenced in your letter do not support USNWR's advertising claims about the reliability of its hospital rankings products, but rather underscore the City Attorney's initial questions. For example, you cite a two-page article from the Journal of General Internal Medicine that, far from substantiating USNWR's statements, raises significant concerns about USNWR's hospital rankings.[1] The article notes that the mortality data used by USNWR "have been shown to be lacking in predicting the quality of care" and that "at one large hospital, for deaths included in the 2019 USNWR rankings attributed to nephrology, nephrology was involved in the care of only 40% of cases (based on internal institution data)."[2] The article also emphasizes the need for adequate risk adjustments, because "[i]nstitutions with a high percentage of inpatients with end-stage diseases may have lower specialty rankings. As a result,

[1] Mendu, M., Kechalia, A., and Eappen, S., *Revisiting US News & World Report's Hospital Rankings—Moving Beyond Mortality to Metrics that Improve Care*, J. Gen. Intern. Med. 36(1):209-10, DOI: 10.1007/s11606-020-06002-x.
[2] *Id.* at p. 209.

patients may be incorrectly discouraged by the lower ranking of a specialty group that takes care of a significant number of end-stage disease patients."[3]

A second article, from the New England Journal of Medicine, criticizes the use of Medicare fee-for-service data that "often lack adequate granularity to produce valid risk adjustment" and the lack of transparency and perverse incentives created by hospital rankings systems receiving payments from ranked hospitals.[4]

Finally, you cite an article in USA Today crediting USNWR's development of a health equity analysis. But, as the article points out, health equity does not factor into USNWR's rankings, and "the representation of nonwhite patients" at the top three ranked hospitals "were all 'lower than the community.'"[5]

The concerns highlighted in the above articles, as well as other questions grounded in the medical literature, were raised in the City Attorney's request for information about USNWR's methodology and payments received from hospitals. You contend that these requests were improper because USNWR's characterization of its rankings products is noncommercial speech or nonactionable opinion, and that our Office is engaged in viewpoint discrimination. But USNWR's statements about the authoritativeness and reliability of its rankings affect sales of USNWR's products and induce hospitals to pay USNWR to license Best Hospitals badges, advertise, and subscribe to granular data. These statements constitute actionable commercial speech, and our Office is authorized to inquire into USNWR's support for these claims.

In a further effort to obtain the necessary information to determine the scope of USNWR's violations of federal and California consumer protection laws, please find attached two subpoenas issued pursuant to the Office's authority under California Business & Professions Code section 16759(b). Please provide the responsive documents and information within 15 calendar days of service of these subpoenas to Deputy City Attorney Karun Tilak and me at Office of the City Attorney, 1390 Market Street, 7th Floor, San Francisco, CA 94102 (alexander.holtzman@sfcityatty.org; karun.tilak@sfcityatty.org). Should you have any questions, please contact Mr. Tilak and me by email or at 415-554-3800.

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[3] *Ibid.*
[4] Bilimoria, K. et al., *Rating the Raters: An Evaluation of Publicly Reported Hospital Quality Rating Systems*, NEJM Catalyst at pp. 9, 11 (Aug. 14, 2019), https://catalyst.nejm.org/evaluation-hospital-quality-rating-systems
[5] Adrianna Rodriguez, *US hospitals struggle to reduce health disparities; Minority patients underrepresented in 4 of 5 hospitals*, USA Today (Jul. 27, 2021), https://www.usatoday.com/story/news/health/2021/07/27/us-news-best-hospital-ranking-includes-first-health-equity-analysis/8090005002/.

Very truly yours,

DAVID CHIU
City Attorney

ALEXANDER J. HOLTZMAN
Deputy City Attorney

Enclosures (2)

EXHIBIT D

SUBPOENA FOR INTERROGATORY RESPONSES

BY PERSONAL SERVICE AND EMAIL

To: U.S. News & World Report, L.P.
c/o C T Corporation System
330 North Brand Blvd., Suite 700
Glendale, CA 91203

This Subpoena for Interrogatory Responses ("Subpoena") is issued to U.S. News & World Report, L.P. ("USNWR" or "you") under the powers conferred to the City Attorney for the City and County of San Francisco by California Business & Professions Code section 16759(b) and California Government Code section 11180 *et seq*. as part of a pending investigation concerning potential violations of California Business and Professions Code section 17200, *et seq.* (the "Unfair Competition Law"). The Unfair Competition Law prohibits USNWR from engaging in any unlawful, unfair, or fraudulent business act or practice. Specifically, this Office's investigation relates to USNWR's advertising representations about its hospital rankings and its failure to disclose payments received from hospitals that it ranks.

YOU ARE HEREBY COMMANDED to provide, within 15 calendar days after service, a response under oath to each interrogatory in **Attachment A**. The following instructions apply to your responses:

1. Each answer must be as complete and straightforward as the information reasonably available to you, including the information possessed by your attorneys or agents, permits. If an interrogatory cannot be answered completely, answer it to the extent possible.
2. If you do not have enough personal knowledge to fully answer an interrogatory, say so, but make a reasonable and good faith effort to get the information by asking other persons or organizations, unless the information is equally available to the asking party.
3. Whenever an interrogatory may be answered by referring to a document, the document may be attached as an exhibit to the response and referred to in the response. If the document has more than one page, refer to the page and section where the answer to the interrogatory can be found.
4. If you are asserting a privilege or making an objection to an interrogatory, you must specifically assert the privilege or state the objection in your written response.
5. Your production must be accompanied by a verification in the form set forth in **Attachment B**, dated and signed under penalty of perjury under the laws of the State of California.

The time period covered by the interrogatories is January 9, 2020, through the present, unless otherwise specified.

Your responses to the enclosed interrogatories must be sent electronically via email to alexander.holtzman@sfcityatty.org and karun.tilak@sfcityatty.org or delivered on or before the deadline to the following address:

Office of the City Attorney
Attn: Alex Holtzman
1390 Market Street, 7th Floor
San Francisco, CA 94102

USNWR must preserve and not modify or destroy or encourage others to modify or destroy any documents or information related to the topics described in Attachment A. The destruction or concealment by anyone subject to this Subpoena may result in our referral to law enforcement for criminal prosecution under California Penal Code section 135.

If you have questions regarding compliance with this Subpoena or need additional time to respond, please contact Deputy City Attorney Alexander Holtzman (Alexander.Holtzman@sfcityatty.org) and Deputy City Attorney Karun Tilak (Karun.Tilak@sfcityatty.org).

Failure to comply with the commands of this Subpoena may subject you to citation for contempt or other penalties before the Superior Court of the State of California.

Signed in the City and County of San Francisco this 9th day of January, 2024.

Alexander J. Holtzman
Deputy City Attorney for the
City & County of San Francisco

ATTACHMENT A

DEFINITIONS:

For purposes of each of Interrogatory Specification:

1. "Hospitals" means hospitals, hospital networks, and entities associated with hospital or hospital networks (e.g., affiliated nonprofits or universities).

2. "USNWR" means U.S. News & World Report, L.P. and any parent, subsidiary, or affiliate corporate entity of U.S News & World Report, L.P.. Where an Interrogatory Specification seeks information regarding payments made by Hospitals to USNWR, please identify the specific corporate entity to which the payment was made.

3. "Describe" means to provide a complete description and explanation of the facts, circumstances, analysis, opinion, and other information relating to the subject matter of the Interrogatory.

4. "Best Hospitals rankings" means Best Hospitals Honor Roll, Best Hospitals by Specialty, Best Hospitals by Medical Procedures and Conditions, Best Children's Hospitals Honor Roll, Best Children's Hospitals by Specialty, and any other ranking of Hospitals published by USNWR.

5. "Best Hospitals badges" means the Best Hospitals Honor Roll badge, Best Hospitals badge, Best Regional Hospitals badge, High Performing Hospitals badge, and any other badge created by USNWR in relation to a ranking of Hospitals and licensed to Hospitals.

INTERROGATORY SPECIFICATIONS:

1. Identify all Hospitals that paid USNWR or BrandConnex, LLC in each year for Best Hospital badge licensing and the amount paid by each Hospital for Best Hospital badge licensing;

2. Identify all Hospitals that paid USNWR in each year for access to USNWR data or data insights, including, but not limited to, USNWR's "Hospital Data Insights" database and the amount paid by each Hospital for access to USNWR data or data insights;

3. Identify all Hospitals that paid USNWR in each year for advertising, including, but not limited to, advertising on USNWR's website and in its Best Hospitals Guidebook and the amount paid by each Hospital for advertising;

4. Identify all Hospitals that paid USNWR in each year to be a Featured Hospital and the amount paid by each Hospital to be a Featured Hospital;

5. Identify all products or services other than those addressed in Interrogatory Specification Nos. 1–4 for which USNWR receives direct or indirect payments from Hospitals;

6. For each product or service identified in response to Interrogatory Specification No. 5, identify all Hospitals that paid for that product or service and the amount paid by each Hospital for that that product or service;

7. Describe USNWR's basis for stating that its Best Hospitals rankings are "[h]ow to find the best medical care in 2023," as stated on the following webpage: https://health.usnews.com/best-hospitals.

8. Describe USNWR's basis for according 19 times greater weight to cystic fibrosis treatment than to sickle cell disease treatment in the Children's Hospital rankings;

9. Describe how, if at all, USNWR has incorporated primary and preventive care in each annual version of the Best Hospitals rankings;

10. Describe USNWR's basis for not including measures of health equity in its rankings of adult Hospitals;

11. Describe how USNWR has adjusted the Medicare fee-for-service dataset to reflect actual patient populations in each annual version of its Best Hospitals rankings;

12. Describe USNWR's basis for believing that Medicare outcomes information from at least 18 months ago accurately reflects current Hospital outcomes;

13. Describe USNWR's basis for using opinion surveys as the exclusive method for ranking Hospitals in ophthalmology, psychiatry, and rheumatology and for incorporating opinion surveys into other specialties ranked by USNWR; and

14. Describe USNWR's relationship with Doximity, Inc., including any equity interest held by USNWR in Doximity, Inc., and any change in that relationship over the last four years.

ATTACHMENT B

VERIFICATION

State of [State]
County of [County]

I, [Name], declare and state as follows:

1. I am employed by U.S. News & World Report, L.P. in the position of [Position];

2. I am authorized by USNWR to make this verification on its behalf;

3. I have reviewed the answers USNWR has provided to interrogatories served on it by the City Attorney for the City & County of San Francisco.

4. I declare under penalty of perjury under the laws of the State of California that the answers USNWR has provided to these interrogatories are true and correct.

.

Signature of Declarant: _____ Date: _____

Printed Name of Declarant: _____

PROOF OF SERVICE

I, Christine Hoang, declare as follows:

I am a citizen of the United States, over the age of eighteen years and not a party to the above-entitled action. I am employed at the City Attorney's Office of San Francisco, Fox Plaza Building, 1390 Market Street, Seventh Floor, San Francisco, CA 94102.

On January 9, 2024, I served the following document:

SUBPOENA FOR INTERROGATORY RESPONSES

on the following persons at the locations specified:

U.S. News & World Report, L.P.
c/o C T Corporation System
330 North Brand Blvd., Suite 700
Glendale, CA 91203

in the manner indicated below:

☒ **BY PERSONAL SERVICE:** I caused a true and correct copy of the above document to be delivered by hand at the above location by a professional messenger service.

☒ **BY ELECTRONIC MAIL:** I sent a true and correct copy of the above document in PDF format from christine.hoang@sfcityatty.org to johnpotter@quinnemanuel.com, michaelwilliams@quinnemanuel.com, and seananderson@quinnemanuel.com.

I declare under penalty of perjury pursuant to the laws of the State of California that the foregoing is true and correct. Executed on January 9, 2024, at San Francisco, California.

/s/ Christine Hoang
Christine Hoang

EXHIBIT E

SUBPOENA FOR PRODUCTION

BY PERSONAL SERVICE AND EMAIL

To: U.S. News & World Report, L.P.
c/o C T Corporation System
330 North Brand Blvd., Suite 700
Glendale, CA 91203

This Subpoena for Production ("Subpoena") is issued to U.S. News & World Report, L.P. ("USNWR" or "you") under the powers conferred to the City Attorney for the City and County of San Francisco by California Business & Professions Code section 16759(b) and California Government Code section 11180 *et seq*. as part of a pending investigation concerning potential violations of California Business and Professions Code section 17200, *et seq.* (the "Unfair Competition Law"). The Unfair Competition Law prohibits USNWR from engaging in any unlawful, unfair, or fraudulent business act or practice. Specifically, this Office's investigation relates to USNWR's advertising representations about its hospital rankings and its failure to disclose payments received from hospitals that it ranks.

YOU ARE HEREBY COMMANDED to produce, within 15 calendar days after service, all non-privileged documents, records, and other materials described in **Attachment A** (collectively, the "Subpoenaed Documents"). Unless otherwise stated, the operative timeframe is January 9, 2020, to the present, including and up to the date of your response to this Subpoena.

All of the Subpoenaed Documents must be sent electronically via email to alexander.holtzman@sfcityatty.org and karun.tilak@sfcityatty.org, via the City Attorney's Office SecureShare FTP portal, or delivered on or before the deadline to the following address:

Office of the City Attorney
Attn: Alex Holtzman
1390 Market Street, 7th Floor
San Francisco, CA 94102

Your production must be accompanied by a certification in the form set forth in **Attachment B**, dated and signed under penalty of perjury under the laws of the State of California by the representative who supervised the response to this Subpoena, that the documents provided are true, correct, and complete copies of all documents responsive to this Subpoena.

USNWR must preserve and not modify or destroy or encourage others to modify or destroy any documents or information related to the topics described in Attachment A. The destruction or concealment by anyone subject to this Subpoena of any Subpoenaed Documents may result in our referral to law enforcement for criminal prosecution under California Penal Code section 135.

If you have questions regarding compliance with this Subpoena, concerns about the format of production, or need additional time to respond, please contact Deputy City Attorney Alex Holtzman (Alexander.Holtzman@sfcityatty.org) and Deputy City Attorney Karun Tilak (Karun.Tilak@sfcityatty.org).

Failure to comply with the commands of this Subpoena may subject you to citation for contempt or other penalties before the Superior Court of the State of California.

Signed in the City and County of San Francisco this 9th day of January, 2024.

Alexander J. Holtzman
Deputy City Attorney for the
City & County of San Francisco

ATTACHMENT A

DEFINITIONS:

For purposes of each Specification:

1. "Hospitals" means hospitals, hospital networks, and entities associated with hospital or hospital networks (e.g., affiliated nonprofits or universities).

2. "USNWR" means U.S. News & World Report, L.P. and any parent, subsidiary, or affiliate corporate entity of U.S News & World Report, L.P.

3. "Agreement" means any written contract, licensing agreement, terms and conditions, or other written document governing the provision of, or access to, a product or service.

4. "Best Hospitals rankings" means Best Hospitals Honor Roll, Best Hospitals by Specialty, Best Hospitals by Medical Procedures and Conditions, Best Children's Hospitals Honor Roll, Best Children's Hospitals by Specialty, and any other ranking of Hospitals published by USNWR.

DOCUMENT SPECIFICATIONS:

1. Documents sufficient to show the corporate structure of USNWR, including but not limited to U.S. News & World Report L.P.'s relationship with any parent, subsidiary or affiliate entity identified in your responses to the accompanying Subpoena for Interrogatory Responses;

2. All agreements between USNWR and BrandConnex, LLC;

3. All agreements between USNWR and RTI International relating to the Best Hospitals rankings;

4. For each Hospital identified in response to Interrogatory Specification Nos. 1–6 in the accompanying Subpoena for Interrogatory Responses, all agreements between that Hospital and USNWR;

5. Documents sufficient to determine USNWR's equity interest in Doximity, Inc. for each year between 2019 and the present; and

6. All USNWR policies and procedures governing the receipt of payments from Hospitals eligible to be considered in USNWR's Best Hospitals rankings.

ATTACHMENT B

CERTIFICATION OF COMPLIANCE WITH SUBPOENA FOR PRODUCTION

State of [State]
County of [County]

I, [Name], declare and state as follows:

1. I am employed by U.S. News & World Report, L.P. ("USNWR") in the position of [Position];

2. The enclosed production of documents and responses to the Subpoena dated [Date] served on USNWR was prepared and assembled under my personal supervision;

3. I made or caused to be made a diligent, complete, and comprehensive search for all Subpoenaed Documents, in full accordance with the instructions and definitions set forth in the Subpoena;

4. The enclosed production of documents and responses to the Subpoena are complete and correct to the best of my knowledge and belief;

5. No documents responsive to the Subpoena have been withheld from this production and response, other than responsive documents or information withheld on the basis of a legal privilege or doctrine; and

6. The Subpoenaed Documents contained in these productions and responses to the Subpoena for Production are authentic, genuine, and what they purport to be.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Declarant: _____ Date: _____

Printed Name of Declarant: _____

PROOF OF SERVICE

I, Christine Hoang, declare as follows:

I am a citizen of the United States, over the age of eighteen years and not a party to the above-entitled action. I am employed at the City Attorney's Office of San Francisco, Fox Plaza Building, 1390 Market Street, Seventh Floor, San Francisco, CA 94102.

On January 9, 2024, I served the following document:

SUBPOENA FOR PRODUCTION

on the following persons at the locations specified:

U.S. News & World Report, L.P.
c/o C T Corporation System
330 North Brand Blvd., Suite 700
Glendale, CA 91203

in the manner indicated below:

☒ **BY PERSONAL SERVICE:** I caused a true and correct copy of the above document to be delivered by hand at the above location by a professional messenger service.

☒ **BY ELECTRONIC MAIL:** I sent a true and correct copy of the above document in PDF format from christine.hoang@sfcityatty.org to johnpotter@quinnemanuel.com, michaelwilliams@quinnemanuel.com, and seananderson@quinnemanuel.com.

I declare under penalty of perjury pursuant to the laws of the State of California that the foregoing is true and correct. Executed on January 9, 2024, at San Francisco, California.

/s/ Christine Hoang
Christine Hoang

EXHIBIT F

From: Hoang, Christine (CAT) <Christine.Hoang@sfcityatty.org>
Sent: Tuesday, January 9, 2024 10:00 AM
To: John Potter; Michael E Williams; Sean Anderson
Cc: Eisenberg, Sara (CAT); Tilak, Karun (CAT); Holtzman, Alexander (CAT)
Subject: Correspondence re U.S. News & World Report
Attachments: 2024-01-09 Response to USNWR.pdf; 2024-01-09 Subpoena (DOCs) to USNWR.pdf; 2024-01-09 Subpoena (ROGs) to USNWR.pdf

[EXTERNAL EMAIL from christine.hoang@sfcityatty.org]

Dear Counsel,

Please see the attached correspondence and enclosed subpoenas.

Best,

Christine Hoang
Legal Secretary
Office of City Attorney David Chiu
(415) 554-4211 Direct
www.sfcityattorney.org

EXHIBIT G

RTI INTERNATIONAL | *turning knowledge into practice*

Methodology

U.S. News & World Report 2023-2024 Best Hospitals: Specialty Rankings

Murrey G. Olmsted
Sarah Lessem
Rebecca Powell
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Denise Bell
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Marshica Stanley
Rachael Allen

August 1, 2023

To Whom It May Concern:

Executive Summary

Please note that the rankings and ratings are subject to change and are not considered final until published on usnews.com/best-hospitals on August 1, 2023.

U.S. News & World Report began publishing hospital rankings in 1990, as "America's Best Hospitals," to identify the medical centers in various specialties best suited to patients whose illnesses pose unusual challenges because of underlying conditions, procedure difficulty, advanced age or other medical issues that add risk.

The specialty rankings have appeared annually since 1990 and their focus on identifying hospitals that excel in treating particularly difficult patients has not changed. To address patients in relatively low-acuity procedures and conditions, a complementary set of ratings, "Best Hospitals: Procedures & Conditions" is available that covers abdominal aortic aneurysm repair, aortic valve surgery, back surgery (spinal fusion), chronic obstructive pulmonary disease, colon cancer surgery, coronary artery bypass surgery, diabetes, heart attack, heart failure, hip fracture, hip replacement, kidney failure, knee replacement, leukemia, lymphoma, & myeloma, lung cancer surgery, ovarian cancer surgery, pneumonia, prostate cancer surgery, stroke, transcatheter aortic valve replacement, uterine cancer surgery, Details of these 21 ratings are available at http://health.usnews.com/health-care/best-hospitals/articles/faq-how-and-why-we-rank-and-rate-hospitals.

The Best Hospitals specialty rankings assess hospital performance in 15 specialties or specialty areas, from Cancer to Urology. In 12 of these, whether and how high a hospital is ranked is determined by an extensive data-driven analysis combining performance measures in three primary dimensions of healthcare: structure, process, and outcomes. In the three other specialties, ranking relies solely on expert opinion.

The structural measures include hospital volume, nurse staffing and other resources that define the hospital environment. The data source for most structural measures is the American Hospital Association (AHA) Annual Survey. Additional resources include the National Cancer Institute's list of NIH-designated cancer centers and the American Nurses Credentialing Center's roster of Nurse Magnet hospitals. New for the 2023-2024 rankings, in addition to hospitals' inpatient volume, outpatient volume will be considered for certain specialties to reflect an increase in utilization of outpatient procedures.

Process is primarily determined by expert opinion surveys of board-certified physicians. We believe expert opinion can measure a hospital's ability to develop and sustain a system that delivers high-quality care. A separate indicator of public transparency was used in four specialties. In

addition, patient experience was incorporated as a separate domain. The basis for this score is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction surveys.

Assessment of outcomes performance relies on patient survival (i.e., risk-adjusted mortality) and the rate at which hospitals discharge patients to home following inpatient care. The Standard Analytical Files (SAF) inpatient limited datasets (SAF data), maintained by the Centers for Medicare & Medicaid Services (CMS) and also referred to as the Medicare claims files, provide detailed claims data, including mortality and discharge disposition for beneficiaries in fee-for-service Medicare. In addition to two risk-adjusted outcomes, for certain specialties, outpatient outcomes are evaluated. For this measure, both inpatient and outpatient SAF data were used to compute hospital-level ambulatory potentially preventable complication rates.

No application, data submission or other action is required for Best Hospitals consideration. All facilities listed in the AHA Annual Survey Database are automatically considered, whether or not they have responded to the AHA's survey.

To be eligible for ranking, hospitals must meet certain criteria based on structural characteristics and also meet a volume/discharge threshold that varies by specialty. Setting discharge minimums ensures that ranking-eligible hospitals have demonstrable experience in treating a set number of complex cases in a given specialty. A hospital that does not meet the minimum requirement in a specialty is still eligible, however, if it was nominated by at least 1% of those who responded to the most recent three years of national physician surveys.

Starting with the 2021-2022 rankings, the project introduced inpatient rehabilitation as a data-driven ranking, which was previously based on expert opinion only. Given the unique nature of rehabilitation care, this specialty has its own eligibility requirements which are covered in ***Section II.A Eligibility***.

Rankings in Ophthalmology, Psychiatry, and Rheumatology are based solely on expert opinion as determined by the physician survey cited above.

For the 2023-2024 rankings, 164 of over 4,500 evaluated U.S. hospitals were ranked in at least one specialty.

Since 1990, the Best Hospitals Honor Roll has recognized a small group of hospitals with high rankings in multiple Best Hospitals specialties. It was extensively revised in 2016-2017 to reduce the effect of the expert opinion measure and to unify the rankings and ratings by

incorporating Best Hospitals Procedures & Conditions ratings. See ***Section V. Honor Roll*** for more details.

Editor's Note: *A key aspect of our journalistic approach is our openness to feedback from diverse stakeholders, including patients, healthcare professionals, and the institutions we evaluate. We receive and welcome a steady stream of suggestions via our team inbox, bhmethodology@usnews.com, and we review and carefully consider feedback. We deeply appreciate the time and thought so many correspondents have invested in formulating these suggestions over the past year and in prior years. Our mission is to serve the best interests of patients and to do so, we, like other reputable journalists, are editorially independent of our employer's business operations. To be clear, we give no consideration to whether a correspondent is affiliated with a hospital or health system that advertises in or maintains other commercial agreements with U.S. News. A hospital's license of a "Best Hospitals" badge or its purchase of advertising or other products from U.S. News does not affect whether or not that institution is ranked, either currently or in the future, and, if ranked, whether it is ranked higher or lower. Journalists who participate in creating rankings or ratings are not involved in the sale of products associated with those rankings or ratings.*

Ben Harder
Managing Editor and Chief of Health Analysis
U.S. News & World Report

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I. Introduction

For families facing a serious or complex medical problem, finding the right hospital is daunting but critical. Decision tools beyond a doctor's recommendation, however, were nonexistent until 1990, when U.S. News & World Report introduced "America's Best Hospitals." That initial assessment was modest, only short alphabetical lists of hospitals that were rated—not ranked—in 12 specialties. In 1991 and thereafter, hospitals were ordinally ranked.

The 2023-2024 Best Hospitals rankings have been drawn from a universe of 4,515 facilities.* The defined universe was the American Hospital Association's (AHA's) Annual Survey of Hospitals, which also provided some data for the rankings analysis. In a small number of cases, two or more AHA hospitals were combined for ranking purposes because they function as a single hospital in one or more specialties but report to AHA as separate facilities.

In 12 of the 15 adult specialty rankings, hospitals receive a composite score based on data from multiple sources. Information about unranked as well as ranked hospitals, accompanied by substantive data, are published online at www.usnews.com/besthospitals/rankings. A print edition publishes ranked hospitals, with somewhat less data displayed than online.

It is essential to use the Best Hospital rankings for their intended purpose—to help consumers determine, together in consultation with their physicians, which hospitals provide the best care for the *most serious or complicated* medical conditions and procedures, such as pancreatic cancer, or replacement of a heart valve in an elderly patient with multiple comorbidities. Relatively commonplace conditions and procedures, such as uncomplicated heart bypass surgery, knee replacement, and heart failure are the purview of a different analysis, Best Hospitals: Procedures & Conditions.†

The underlying methodology for the Best Hospitals rankings was created by the National Opinion Research Center (NORC) at the University of Chicago in the early 1990s. NORC collected the data and compiled the rankings from 1993 to 2004. RTI International,‡ Research Triangle Park, N.C., has produced the rankings from 2005 to the present. Over time, the methodology has been refined and extended—by incorporating patient safety data in 2009 (removed in 2019), for example, and measures for voluntary data transparency in Cardiology, Heart & Vascular Surgery (added in 2016-2017), and patient experience in all specialties (added in 2019). Large-scale enhancements are

* Military installations, federal institutions, and acute long-term care facilities and institutional hospital units (e.g., prison hospitals, college infirmaries) are excluded from the data-driven specialties.

† Best Hospitals: Procedures & Conditions was launched in May 2015 and rates hospital performance in 21 procedures & conditions.

‡ RTI International is a trade name of Research Triangle Institute.

always under consideration such as the change introduced in the 2019 rankings for outcomes where a new risk-adjusted mortality measure and a measure of the rate at which hospitals discharge patients to home following inpatient care were introduced.

The roster of specialties has been revised over the years as well. AIDS care, for example, was included in 1990 but was dropped in 1998 because most HIV/AIDS care had shifted to the outpatient setting. Pediatrics was moved out of the Best Hospitals universe in 2007 when separate Best Children's Hospitals rankings were created. In the 2021-2022[§] rankings, Nephrology was removed from the list of Best Hospitals specialties and was replaced with a kidney failure Procedures & Conditions rating, which covered nearly all of the same hospital admissions.

The current 15 specialty rankings are:

- Cancer
- Cardiology, Heart & Vascular Surgery
- Diabetes & Endocrinology
- Ear, Nose & Throat
- Gastroenterology & GI Surgery
- Geriatrics
- Obstetrics & Gynecology
- Neurology & Neurosurgery
- Ophthalmology
- Orthopedics
- Pulmonology & Lung Surgery
- Psychiatry
- Rehabilitation
- Rheumatology
- Urology

A. Data-Driven Rankings

Rankings in 12 of the 15 specialties are based largely on objective data. An overall score (i.e., the U.S. News score) is assigned to hospitals in all data-driven specialties (i.e., all specialties other than Ophthalmology, Psychiatry, and Rheumatology, in which rankings are determined solely through expert opinion).

[§] Because the rankings are released in the middle of the year, U.S. News labels them with the current and following years when referring to them. This applies to the Best Children's Hospitals rankings as well.

A hospital's overall score reflects performance in three interlocked dimensions of healthcare: structure, process, and outcomes. The relationship was described by Avedis Donabedian in 1966; his model's fundamental soundness has been widely accepted.[1-5]

Structure refers to hospital resources related directly to patient care. Examples in the Best Hospitals rankings methodology include intensity of nurse staffing, availability of desirable technologies and patient services, and special status conferred by a recognized external body, such as designation as a Nurse Magnet hospital by the American Nurses Credentialing Center (ANCC) or as a National Cancer Institute (NCI) comprehensive or clinical cancer center by the National Institutes of Health (NIH).

Healthcare also is shaped by the *process* of delivering care, encompassing diagnosis, treatment, prevention, and patient education. Because many direct measures of process have limited relevance to the types of highly complex specialty care that is the focus of this project, a measure of expert opinion is used as a proxy for process quality. Specifically, process is represented by the expert opinion of a hospital to develop and sustain a system that delivers high-quality care.

The most evident *outcomes* measure is death, typically measured by *risk-adjusted mortality* (the likelihood of death when the patient's condition and the complexity of the case are taken into account). To address the role of socioeconomic factors in outcomes, the rankings include an adjustment to risk-adjusted mortality to take into account patients who are both Medicare- and Medicaid-eligible. Another outcome included is discharging patients to home, which focuses on the rate at which patients go home directly after inpatient care rather than being transferred to another facility for continued care. This measures how effective inpatient care delivered by hospitals is at addressing patient medical needs. For the 2023-2024 rankings, outpatient outcomes are included in two specialties, Orthopedics and Urology. New outcome measures quantify the ability of hospitals to reduce complications related to procedures conducted on an outpatient basis.

Available metrics do not always neatly conform to a single dimension. Patient experience, for example, is an outcome that reflects both the patient's satisfaction with the care they received as well as how well the hospital addressed their medical needs. Although patient experience overlaps with both process and outcomes, we consider it a fourth component in the Best Hospitals methodology, evaluated separately from structure, process/expert opinion, and outcomes.

A fifth component, public transparency, was added to Cardiology, Heart & Vascular Surgery for the 2016-2017 rankings. Hospitals received credit for participating in certain American College of Cardiology (ACC), Society of Thoracic Surgeons (STS), or American Heart Association data-reporting initiatives if they also agreed to allow their ACC-, STS-, or American Heart Association-calculated results to be publicly reported on the organizations' websites. Beginning with the 2020-

2021 rankings, hospitals that participate in and publicly report through the American Heart Association's Get With The Guidelines Stroke program received credit in Neurology and Neurosurgery rankings. A transparency credit was added to Obstetrics & Gynecology rankings for the 2022-2023 rankings; hospitals received credit if they participated in the annual U.S. News Maternity Services Survey. New for the 2023-2024 rankings, hospitals receive credit in Pulmonology & Lung Surgery rankings if they participate in and publicly report via STS General Thoracic Surgery Database (GTSD).

Many of the individual measures in the data-driven rankings come from secondary data sources such as the American Hospital Association (AHA) Annual Survey Database, which provides information about various structural hospital characteristics.

The five major components of the data-driven rankings are briefly described below and in greater detail later in this report.

Structure

These elements represent volume (i.e., discharges), technology, and other features that characterize the hospital environment. Some elements such as nurse staffing, ICU specialists, and Nurse Magnet status are included in all specialties, while other elements are specialty-specific. The source for many of these data elements in the 2023-2024 rankings was the 2021 AHA Annual Survey, the most recent available.

The source of volume data was the Standard Analytical Files (SAF), maintained by the Centers for Medicare & Medicaid Services (CMS) and also referred to as the Medicare claims files, which provide detailed claims data, for all traditional (fee-for-service) Medicare beneficiaries who use hospital inpatient services. Two specialties, Obstetrics & Gynecology and Ear, Nose, & Throat, included procedures performed in hospital based outpatient departments starting from the 2023-2024 publication. These procedures were identified using 3M's Ambulatory Potentially Preventable Complications (AM-PPCs) grouper software, which assigns each episode to a Procedure Sub Group (PSG) using HCPCS or ICD codes (see Table 6 for more details). To account for Medicare Advantage patients, volume was calculated for hospitals in each specialty using an adjustment described below (see Number of Patients subsection under **Section II.B Structure**, below). As a result, the volumes reported represent estimates rather than observed volumes of care at each hospital.

Process/expert opinion

The process component of the overall score is represented by experts' opinion of a hospital. For these rankings, the concept of expert opinion speaks to an institutional ability to develop and sustain a system that delivers high-quality care to especially challenging patients.

A hospital's expert opinion score is based on the average number of nominations from the three most recent annual surveys of board-certified physicians conducted for the Best Hospitals rankings which, for the 2023-2024 rankings, were conducted in 2021, 2022, and 2023.

The 2023 sample was drawn from the Doximity Masterfile. Similar to the American Medical Association (AMA) Physician Masterfile, which was used as the sampling frame prior to 2016, Doximity's comprehensive Physician Database includes nearly every practicing U.S. physician. More information on the sampling approach for the physician survey can be found in ***Section II.D Process/Expert Opinion***.

The physician sample was stratified by census region— Northeast, Midwest, South and West (https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf)—and by specialty to ensure appropriate representation. The final aggregated sample included both medical and osteopathic physicians in all 50 states and the District of Columbia.

The surveyed physicians were asked to nominate the hospitals in their specific field of care, leaving aside issues of expense or location, that they consider best for patients with serious or difficult conditions. They could list as many as five hospitals and the scores were adjusted based on a physician's current affiliation. The effect of these adjustments is to give higher weight to the opinions of unaffiliated physicians than to those of affiliated physicians, particularly in cases where a hospital received a relatively large proportion of its nominations from affiliated physicians.

Outcomes

The primary outcomes measure in 11 of the 12 data-driven rankings (except Rehabilitation) is 30-day patient survival (i.e., how many patients are alive at 30 days after inpatient hospital admission). Like the volume indicator, the mortality measure is derived from SAF data, so only patients receiving care under traditional Medicare and 65 years of age or older were included. As in previous years, Medicare Advantage patients are not included in the outcomes. For each hospital and specialty, U.S. News computed an adjusted mortality rate based on the Medicare Severity Diagnosis-Related Group (MS-DRGs) appearing in the SAF data for the group of DRGs that appear in *Appendix B* for each of the specialties. This method was applied to the three most recent

calendar years (CY2019, CY2020, and CY2021) of Medicare claims submitted for reimbursement to CMS that appeared in the SAF data.

Starting with the 2019-2020 rankings, a discharging patients to home measure was included. This measure reflects the risk-adjusted rate at which patients are discharged to home rather than another facility (e.g., skilled nursing facility, long-term acute care facility, another acute care hospital) for additional care.

Both of the claims-based outcomes described above were risk-adjusted using a hierarchical logistic regression model that controlled for potential confounders, with a random intercept for hospital identity. Details on the model specified for each cohort are described in ***Section II.C Outcomes***. In all instances, continuous variables were treated as such in our composite modeling in order to make maximum use of the information contained in the variable, and to minimize the risk of measurement error due to categorization.

New with the 2023-2024 rankings, an outcome measure of potentially preventable complications following certain outpatient procedures was added to the methodology for Orthopedics and Urology. This measure is described in ***Section II.C Outcomes***.

For inpatient rehabilitation, mortality is not a meaningful outcome as it rarely occurs, and the main focus of treatment is on functional improvement, community discharge, and avoidance of future acute care where possible. As a result, the rehabilitation rankings now include measures focused on avoiding readmissions and successful discharge to the community. These measures are described in more detail in ***Section II.C Outcomes***.

Patient Experience

Patient experience is used to assess the patient-reported outcomes of care at hospitals eligible for the rankings. This measure reflects the patient experience of care as reported on the HCAHPS survey of recently discharged patients or family members for patients who have died since hospital discharge. The rankings utilize the linear mean score rather than the HCAHPS star rating for the ranking calculation because the former is a continuous measure and provides more information for analysis. However, the star ratings are shown in the ranking tables online and in the methodology report as they provide an accessible and easy way for consumers to understand the score. The HCAHPS dataset used for analysis was dated April 1, 2021 through March 31, 2022.

Public Transparency (Cardiology, Heart & Vascular Surgery, Obstetrics & Gynecology, Neurology & Neurosurgery, and Pulmonology & Lung Surgery)

In the Cardiology, Heart & Vascular Surgery, Obstetrics & Gynecology, Neurology & Neurosurgery, and Pulmonology & Lung Surgery specialty rankings, hospitals receive a credit if they participate in and publicly report via key clinical registries or public transparency programs. A brief description of the transparency measures is provided below.

In the Cardiology, Heart & Vascular Surgery specialty, since 2016, hospitals have received credit worth up to 3% of the overall score for participating in transparency initiatives. This year, hospitals received credit by publicly reporting quality metrics through websites maintained by the American College of Cardiology (www.cardiosmart.org), the Society of Thoracic Surgeons (www.sts.org), and the American Heart Association (https://qualitynearme.heart.org/GWTGPublicReporting). This year's rankings considered each hospital's public reporting status as of August 31, 2022 for the American Heart Association registries and December 5, 2022 for the ACC registry and December 23, 2022 for the STS registry. Support for the use of this measure consists of a demonstrated association between public reporting of evidence-based hospital performance metrics with better quality of care and improved hospital performance.[6-11]

A similar transparency measure, added in 2020, is worth 3% of the overall score for the Neurology & Neurosurgery specialty. Hospitals voluntarily reporting stroke care measures to the public through the Get With The Guidelines (GWTG)-Stroke quality improvement program of the American Heart Association (https://www.heart.org/en/professional/quality-improvement/get-with-the-guidelines/get-with-the-guidelines-stroke) as of August 31, 2022 received credit.

A similar transparency measure, added in 2022, is worth 3% of the overall score for the Obstetrics & Gynecology specialty. Hospitals voluntarily reporting on the U.S. News Maternity Services Survey in 2022 received credit; U.S. News uses data from the Maternity Services Survey to produce Best Hospitals for Maternity Care ratings.

A new transparency measure, added in 2023, is worth 3% of the overall score for the Pulmonology & Lung Surgery specialty. Hospitals that submit their Lobectomy data via the Society of Thoracic Surgeons (STS) General Thoracic Surgery Database (GTSD) and were publicly reporting their results by December 31, 2022 were recognized in the rankings.

Weighting

Weights are shown in ***Table 1.***

Table 1. 2023-24 Overall Weight by Component

Component	Cardiology, Heart & Vascular Surgery, Obstetrics & Gynecology, Neurology & Neurosurgery, and Pulmonology & Lung Surgery	Rehabilitation (%)	All Other Specialties (%)
Outcomes	45%	30%	45%
Structure	35%	35%	35%
Process/expert opinion	12%	35%	15%
Patient experience	5%	0%	5%
Public transparency	3%	0%	0%

B. Expert Opinion-Based Rankings

In the three specialties—Ophthalmology, Psychiatry, and Rheumatology—in which ranking reflects the results of the expert opinion survey alone, that is because many structural and outcomes measures are not applicable since care is largely delivered on an outpatient basis and poses a very small risk of death. For this report, these specialties are referred to as *expert opinion-based specialties* and the associated rankings as *expert opinion-based rankings*.

C. Report Outline

The remainder of this report is structured as follows:

- ***Section II*** describes the data-driven components in detail. (For a more detailed review of the foundation, development and use of the individual measures and the composite index, see "Best Hospitals: A Description of the Methodology for the Index of Hospital Quality."[12])
- ***Section III*** describes the process used to develop the rankings for the three expert opinion-based specialties.
- ***Section IV*** describes the number of hospitals ranked in at least one specialty.
- ***Section V*** presents the Honor Roll, an additional classification that denotes excellence across a broad range of specialties, procedures and conditions.

- ***Section VI*** summarizes changes in the methodology for the current year.
- ***Section VII*** describes enhancements under consideration.

II. Data-Driven Rankings

This section describes hospital eligibility criteria and the procedures used to derive the overall score for the 12 data-driven specialties. Hospitals ranked in 2023-2024 as a result of new or merged corporate entities in the AHA database are treated as single units and are listed as such in this report.

A. Eligibility

All 4,515 community hospitals included in the FY2021 AHA universe were automatically considered for ranking;[**] no request, application or other action was required. For the data-driven specialties other than rehabilitation, the methodology involved two stages of eligibility criteria; hospitals had to satisfy the requirements of each stage to be eligible in a given specialty.

Stage 1. A hospital that met *any* of the following criteria was initially eligible:

- Member, Council of Teaching Hospitals (COTH)
- Medical school affiliation (AMA or American Osteopathic Association [AOA])
- At least 200 hospital beds set up and staffed (from FY2021 AHA Annual Survey of Hospitals, variable BDTOT)
- At least 100 hospital beds set up and staffed *and* availability of at least four of eight important key technologies (see ***Advanced Technologies***).

Hospitals that met Stage 1 and responded to the AHA Annual Survey of Hospitals in 2019 and 2020 but not in 2021 remained eligible. For such hospitals, we used survey data from 2020. Nonresponders lacking data from the current survey and one of the previous two surveys were evaluated without AHA data. A total of 2,320 hospitals successfully passed the first stage of the eligibility process.

Stage 2. To be eligible for ranking in a specialty, a hospital had to have a specified number of discharges in a defined list of specialty-specific diagnoses submitted for CMS reimbursement in CY2019, CY2020, and CY2021 combined. In Obstetrics & Gynecology and Ear, Nose, & Throat

[**] Military installations, federal institutions, rehabilitation, and acute long-term care facilities, and also institutional hospital units (e.g., prison hospitals, college infirmaries) were excluded.

specialties, the number of outpatient volume was incorporated when computing discharge minimums. Setting discharge minimums involving complex care ensures that ranking-eligible hospitals can demonstrate that they have treated adequate numbers of challenging cases in a given specialty. Minimums for all specialties will be reviewed for future rankings and adjusted as needed.

Table 2 presents the minimum Medicare Advantage (MA)-adjusted discharge volumes (unless otherwise specified) required for eligibility and numbers of hospitals meeting the MA-adjusted volume criteria for the data-driven specialties (see ***Section II.B Structure***). In Diabetes & Endocrinology, Ear, Nose & Throat, and Obstetrics & Gynecology, both the MA-adjusted volume and unadjusted volume were considered and hospitals had to have volumes that met the minimum values for each. Additionally, in Ear, Nose & Throat and Obstetrics & Gynecology, outpatient data was included in the total discharge volume. Therefore, hospitals in these specialties had to meet both total volume and inpatient volume thresholds.

Table 2. Discharge Thresholds by Specialty

Specialty	Total Discharge Minimum (Unadjusted)	Inpatient Minimum (Unadjusted)	Total Discharge Minimum (MA-Adjusted)	Surgical Minimum (MA-Adjusted)
Cancer	—	—	187	36
Cardiology, Heart & Vascular Surgery	—	—	1,725	800
Diabetes & Endocrinology	210	—	226	—
Ear, Nose & Throat[a]	240	80	12	3
Gastroenterology & GI Surgery	—	—	429	115
Geriatrics	—	—	2,570	—
Neurology & Neurosurgery	—	—	247	21
Obstetrics & Gynecology[a]	200	67	16	4
Orthopedics	—	—	256	228
Pulmonology & Lung Surgery	—	—	1,277	—
Rehabilitation	50	—	—	—
Urology	—	—	40	19

[a] Total discharge minimums for this specialty incorporate outpatient volume.

If a hospital did not meet the volume requirements, it was still considered eligible in a specialty if its expert opinion score was 1% or greater. The total number of hospitals in each specialty that became eligible due to their expert opinion score is also shown in ***Table 3***.

A total of 2,311 hospitals met the volume criteria in at least one specialty, and nine other hospitals became eligible because they had a 1% or higher expert opinion score in at least one specialty. In all, 2,320 unique hospitals were eligible for at least one data-driven ranking.

Table 3. Number of Eligible Hospitals by Specialty

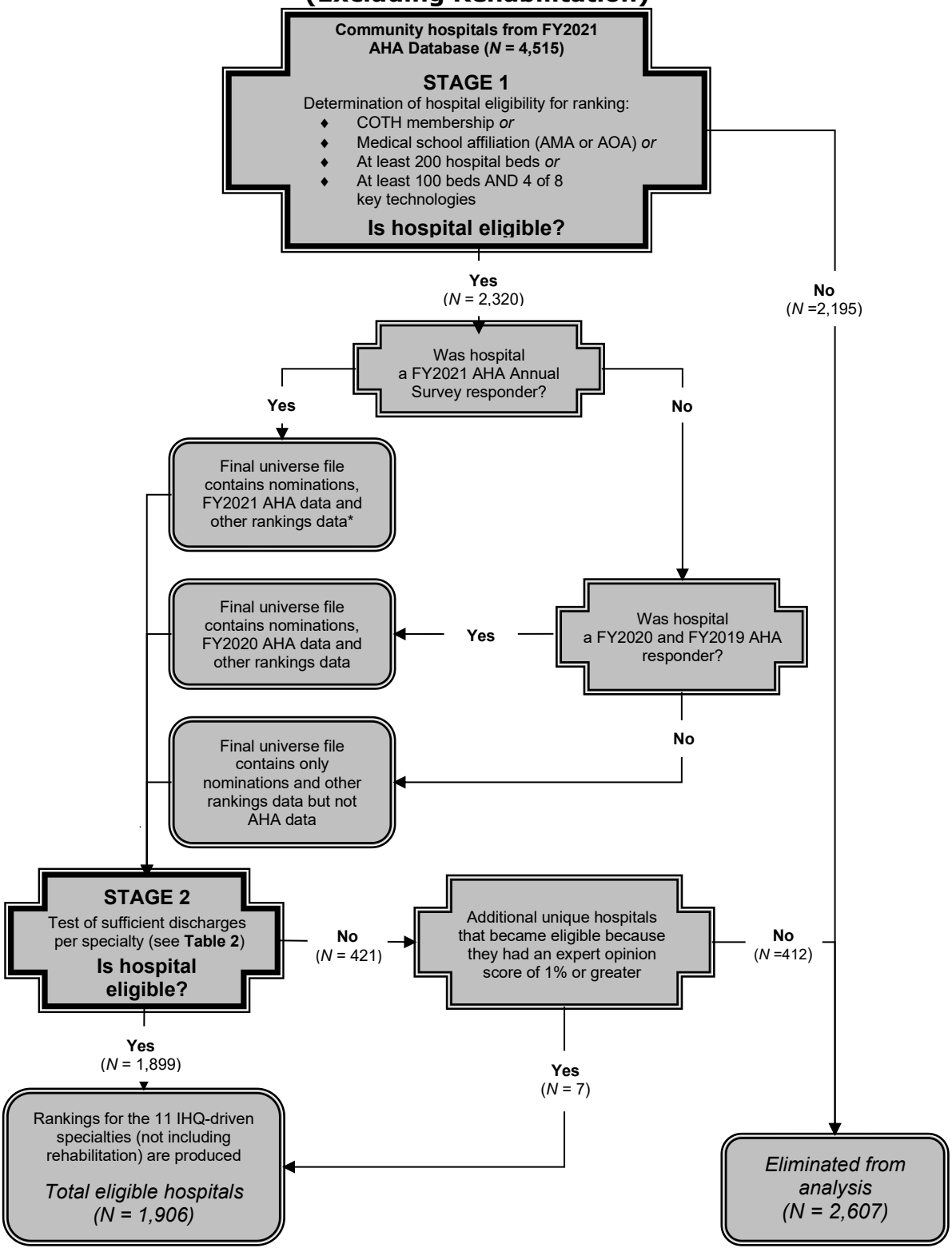
Specialty	Additional Eligibility Criteria	Number of Eligible Hospitals Based on Minimum Discharges	Additional Hospitals with ≥ 1% Expert Opinion Score	Final Eligible Total
Cancer		898	1	899
Cardiology, Heart & Vascular Surgery	Must be eligible for Procedures & Conditions in one of the cardiac services cohorts for the current year	779	0	779
Diabetes & Endocrinology		699	1	700
Ear, Nose & Throat		140	4	144
Gastroenterology & GI Surgery		1,581	0	1,581
Geriatrics	Must offer at least one of the following services: - arthritis treatment center, - adult day care program, - patient representative services, - geriatric services, - meals on wheels, - assisted living, - transportation to health facility, or - Alzheimer's center service	1,513	0	1,513
Neurology & Neurosurgery	Must have a ratio of surgical to total discharges at or above the 25th percentile	1,245	0	1,245
Obstetrics & Gynecology	Must be eligible for the U.S. News Maternity Services survey for the current year	280	3	283
Orthopedics		1,681	0	1,681
Pulmonology & Lung Surgery	Must have a ratio of sepsis to all other cases that is lower than 3 standard deviations above the mean	1,695	1	1,696
Rehabilitation		1,038	3	1,041
Urology		1,472	0	1,472
	Total (unique hospitals)[a]	2,311	9	2,320

[a] The totals are not sums. The same hospitals may be eligible in multiple specialties. This line represents the total unique hospitals in each category across all specialties.

In Geriatrics, an additional step excluded hospitals classified in the AHA survey data as surgical hospitals or as specializing in cancer, heart or orthopedics. The basis for the exclusions was that Geriatrics as defined in Best Hospitals represents a broad swath of patients across all service lines. A surgical or specialty hospital treats subsets of those patients whose clinical needs may not be comparable. Similarly, cancer hospitals were excluded from Diabetes & Endocrinology, Orthopedics, Neurology & Neurosurgery, and Pulmonology & Lung Surgery.

We then conducted separate analyses for each specialty to rank the top 50 hospitals in each data-driven specialty and provide overall scores for all evaluated hospitals. ***Figure 1*** illustrates the eligibility and analysis process for the data-driven specialties, as described in the steps above.

Figure 1. Eligibility Process, Data-Driven Specialties (Excluding Rehabilitation)



* To account for inconsistent reporting to the AHA survey during 2021, data used will incorporate the most recent available measures from FY2021, FY2020, or FY2019.

Eligibility Requirements for Rehabilitation

No application, data submission or other action is required by inpatient rehabilitation facilities (IRFs) to be considered in the rehabilitation specialty rankings. Except for military and federally owned hospitals, all facilities listed in the AHA annual survey database of U.S. hospitals are automatically considered but, as with other Best Hospitals specialty rankings, must meet a series of eligibility requirements in order to be evaluated in rehabilitation. Eligibility in rehabilitation has two paths for consideration. For the first path to eligibility, facilities are eligible if they appear in the December 2022 public use files for the CMS Care Compare reporting program under the "inpatient rehabilitation facilities" provider type (link: https://www.medicare.gov/care-compare/?providerType=InpatientRehabilitation) have an aggregate volume of "Conditions treated" in Stroke, Brain injury (traumatic), Brain disease or condition (non-traumatic), Spinal cord injury (traumatic), Spinal cord disease or condition (non-traumatic), and Nervous system disorder (excluding stroke) of 50 or more in Care Compare. If available from the Uniform Data System for Medical Rehabilitation (UDSMR)[††] or American Medical Rehabilitation Providers Association's eRehabData[‡‡], two key registries in rehabilitation, all-payor volumes for these conditions have been used to determine eligibility. Note that for certain conditions a facility's Medicare volume, as reported in Care Compare, may be substantially lower than its total volume. A total of 1,038 hospitals were eligible in rehabilitation under these criteria.

A second path is also available for facilities that provide acute inpatient rehabilitation services but are not included in the IRF component of Care Compare reporting, including many IRFs located in Maryland (which may opt into but are not required to participate in the IRF Prospective Payment System, known as IRF PPS) and certain specialized long-term care hospitals. Specifically, hospitals that were exempt from the IRF component of Care Compare and had an expert-opinion score of 1% or higher based on the most recent three years of U.S. News national physician surveys in rehabilitation are eligible, regardless of whether they meet all the criteria for the first path for eligibility. An additional 3 hospitals qualified under this path to eligibility. In total, 1,041 hospitals were eligible to be ranked in rehabilitation. Many, but not all, of these hospitals were also eligible in other data-driven specialties.

Being eligible for ranking does not guarantee that a hospital will be ranked. While all eligible hospitals are assigned a score in rehabilitation, only those achieving the highest scores are ranked as Best Hospitals (i.e., 1-50).

[††] https://www.udsmr.org/

[‡‡] https://web2.erehabdata.com/erehabdata/index.jsp

In addition, while not being eligible, facilities listed in the AHA survey database as having a primary service code indicating that they are a Rehabilitation hospital (AHA variable: SERV=46), or the AHA service of "physical rehabilitation care" (AHA variable: REHABHOS) and are located in the state of Maryland, or have received accreditation for inpatient rehabilitation from the Commission on Accreditation of Rehabilitation Facilities (CARF) are considered to be rehabilitation facilities and are listed in the directory on the U.S. News website, but have not received scores or a rank. There were 139 such rehabilitation facilities.

B. Structure

The structural dimension defines the resources, human and otherwise, available at hospitals for treating patients. Healthcare research overwhelmingly supports the use of a structural measure to assess quality of care. No prior research, however, has identified a structural indicator that summarizes all others or that adequately represents the structural dimension construct on its own. Therefore, the structural component is represented by a composite variable consisting of different specialty-specific measures with different weights.

For the 2023-2024 rankings, the source of most structural elements was the FY2021 AHA Annual Survey Database. Additional components came from external organizations including the National Cancer Institute (NCI), American Nurses Credentialing Center (ANCC), Foundation for the Accreditation of Cellular Therapy (FACT), National Institute on Aging (NIA), National Association of Epilepsy Centers (NAEC), Commission on Accreditation of Rehabilitation Facilities (CARF), National Institutes of Health (NIH), American Hospital Directory, and CMS.

AHA Annual Survey

AHA has surveyed hospitals annually since 1946. The AHA Annual Survey of Hospitals is the most comprehensive and dependable database of information on institutional healthcare,[13] with an average annual response rate of 80%. The database contains hospital-specific data items for more than 6,100 hospitals and healthcare systems. More than 1,300 data fields cover organizational structure, personnel, hospital facilities and services, and financial performance. (The specific mapping of Best Hospitals variables to AHA data elements is shown in ***Appendix A***.)

Hospitals that did not respond to the 2021 AHA Annual Survey but responded to the 2020 survey were evaluated using their 2020 responses. Hospitals that did not respond to the AHA survey in either year were evaluated without AHA data, receiving no points for measures in the AHA annual survey.

The following items from the AHA Annual Survey Database provided most of the structural score for the data-driven specialties.

Advanced Technologies

The elements in this measure are reviewed every year in each specialty to remain consistent with the key technologies and advanced care expected from a "best hospital." Credit was awarded to hospitals that either (1) own or provide a specified service at the hospital or its subsidiaries, (2) provide the service through their health system (in their local community), or (3) provide the service through formal arrangements with local institutions not in their health system.

Of the 15 technologies that are relevant in one or more specialties, 8 comprise the Technology index that is one of the eligibility doorways: Hospitals that provide at least 4 of the 8 relevant technologies and have 100 beds or more are eligible for ranking (see ***Section II.A Eligibility***).

Brief descriptions of the technologies in the 2023-2024 index follow. The definitions are taken largely from the 2021 AHA Annual Survey, expanded as necessary:

- **Ablation of Barrett's esophagus.** A premalignant condition that can lead to adenocarcinoma of the esophagus. The nonsurgical ablation of premalignant tissue in Barrett's esophagus is done by the application of thermal energy or light through an endoscope passed from the mouth into the esophagus.
- **Assistive technology center.** A program providing access to specialized hardware and software with adaptations allowing individuals greater independence with mobility, dexterity, or increased communication options.
- **Electrodiagnostic services.** Diagnostic testing services for nerve and muscle function such as nerve conduction studies and needle electromyography.
- **Computer-assisted orthopedic surgery.** A group of orthopedic devices that produce three-dimensional images to assist in surgical procedures.
- **Computed tomography (CT) scanner.** Computed tomographic scanner for head or whole-body scans.
- **Diagnostic radioisotope services.** A procedure that uses radioactive isotopes (radiopharmaceuticals) as tracers to detect abnormal conditions or diseases.
- **Endoscopic retrograde cholangiopancreatography.** A procedure in which a catheter is introduced through an endoscope into the bile and pancreatic ducts.

Injection of contrast material permits detailed x-ray of these structures. The procedure is used diagnostically as well as therapeutically to relieve obstruction or remove stones.

- **Endoscopic ultrasound.** A specially designed endoscope that incorporates an ultrasound transducer to obtain detailed images of organs in the chest and abdomen. The endoscope can be passed through the mouth or anus. Combined with needle biopsy, the procedure can assist in diagnosis of disease and staging of cancer.

- **Full-field digital mammography.** A procedure that combines x-ray generators and tubes used in analog screen-film mammography with a detector plate that converts the x-rays into a digital signal to help diagnose breast cancer.

- **Image-guided radiation therapy.** An automated system that provides high-resolution x-ray images to pinpoint tumor sites, adjusts patient positioning as necessary and completes treatment within the standard treatment time slot, allowing for more effective cancer treatments.

- **Intensity-modulated radiation therapy (IMRT)**. A type of radiation therapy used to treat tumors. IMRT manipulates beams of radiation to the shape of the tumor. Beams of varying intensity can be used to radiate the tumor with precision. By using IMRT, physicians can focus on the tumor and avoid exposing healthy tissue to radiation, which causes a variety of negative treatment side effects.

- **Multislice spiral computed tomography (CT).** A procedure that uses x-rays and data processing to produce multiple narrow slices that can be recombined into detailed three-dimensional pictures of the internal anatomy.[§§]

- **PET/CT scanner.** A machine that combines positron emission tomography (PET) and CT capabilities in one device to provide metabolic functional information and images of physical structures in the body for diagnostics and monitoring chemotherapy, radiotherapy, and surgical planning.

- **Prosthetic and orthotic services.** Services providing comprehensive prosthetic and orthotic evaluation, fitting, and training.

- **Robot-assisted walking therapy.** A form of physical therapy that uses a robotic device to assist patients who are relearning how to walk.

- **Robotic surgery.** The use of computer-guided imaging and manipulative devices to perform surgery without the surgeon's direct intervention.

[§§] The indicator for multislice spiral CT includes both standard (less than 64 slices) and advanced (64 or more slices) versions of the technology. Hospitals can receive credit for either version.

- **Shaped-beam radiation.** A noninvasive procedure that delivers a therapeutic dose of radiation to a defined area of a tumor to shrink or destroy cancerous cells.

- **Single-photon-emission CT.** A nuclear medicine imaging technology that combines radioactive material with CT imaging to highlight blood flow to tissues and organs.

- **Simulated rehabilitation environment.** Rehabilitation focused on retraining functional skills in a contextually appropriate environment (simulated home and community settings) or in a traditional setting (gymnasium) using motor learning principles.

- **Stereotactic radiosurgery.** A radiotherapy modality that delivers a high dosage of radiation to a discrete treatment area in as few as one treatment session. Variants include Gamma knife and Cyberknife.

- **Transplant services.** Includes Medicare-approved organ transplant programs in heart, liver, lung, or kidney transplant recognized by CMS. In addition, hospitals listed as bone marrow and tissue transplant centers by AHA are recognized. Transplant services are specific to the specialty. In the Cancer specialty, transplant services include bone marrow and other tissue transplants; Gastroenterology & GI Surgery includes liver transplant; Cardiology, Heart & Vascular Surgery includes heart transplant and tissue transplant; Pulmonology & Lung Surgery includes lung transplant; Orthopedics includes tissue transplant.

Specialty-specific mixes of key technologies are used in computing the U.S. News scores (see ***Section II.G Calculation of the Overall Score for the Data-Driven Specialties***). ***Table 4*** presents the complete list of key technologies considered for each specialty.

Number of Patients

This measure reflects the volume of medical and surgical discharges in indicated specialty-specific MS-DRG groupings submitted for CMS reimbursement in CY2019, CY2020, and CY2021 combined. The list of MS-DRGs in each specialty is displayed in ***Appendix B***. Volume is part of the structural score in all 12 data-driven specialties. Volumes include all cases, including transfers, that appeared in SAF data for the specified MS-DRGs listed in ***Appendix B***. Volume data, as described on Page 4, include Medicare fee-for-service patients who were 65 years of age or older; Medicare Advantage managed-care patients are not included in SAF data. Patient selection for outcomes analysis is the same, as described on Page 5. To account for Medicare Advantage patients, reported volumes received an adjustment based on the volume reported in the MedPAR datasets, which include both traditional Medicare and Medicare Advantage patients. An adjustment was calculated for each hospital based on the proportion of Medicare Advantage patients found in the MedPAR

datasets for the three years of data were present in the SAF data. The total SAF volume of hospital care for each specialty was then adjusted by this factor. For two specialties, Obstetrics & Gynecology and Ear, Nose, & Throat, the adjustment was made after combining inpatient and outpatient volume. In doing so, the cap was imposed based on a 2:1 outpatient to inpatient volume ratio in order to depress the influence of extreme outliers. This MA-adjusted volume was then used for the volume measure in each specialty. MedPAR data were not available for a small number of eligible hospitals so, for these hospitals only, we estimated the MA-adjustment based on the location of the hospital—specifically the Medicare Advantage penetration rate for the county where the hospital is located. The numerator for this location-based calculation was the number of fee-for-service discharges meeting the criteria for inclusion in the specialty. The denominator was the proportion of Medicare beneficiaries enrolled in fee-for-service (as opposed to Medicare Advantage) in the county in which the hospital is located. The denominator was calculated by subtracting from 1.0 the CMS Medicare Advantage penetration estimates, expressed as a decimal less than 1.0, for July 2020, the approximate midpoint of the analysis time period.

As a result of the above methods, the volumes reported represent estimates rather than observed volumes of care at each hospital. Note that the new, MedPAR-based adjustment generally had a smaller impact on volume than the location-based method that was used for all hospitals last year. Since most hospitals received the MA-adjustment based on MedPAR for the 2023-2024 rankings, MA-adjusted volumes for most hospitals are somewhat lower than in 2022. Because scoring of volume measures is relative, a decrease in a hospital's MA-adjusted volume from 2022 to 2023 does not necessarily indicate a decrease, and may result in an increase, in the hospital's performance on the measure.

Table 4. Technologies by Specialty

Technology	Technology Index	Cancer	Cardiology, Heart & Vascular Surgery***	Diabetes & Endocrinology	Ear, Nose & Throat	Gastroenterology & GI Surgery	Geriatrics	Obstetrics & Gynecology	Neurology & Neurosurgery	Orthopedics	Pulmonology & Lung Surgery	Rehabilitation	Urology
Ablation of Barrett's esophagus						●							
Assistive technology center												●	
Computer-assisted orthopedic surgery										●			
Computed tomography (CT) scanner												●	
Diagnostic radioisotope services	●			●		●			●		●		●
Electrodiagnostic services												●	
Endoscopic retrograde cholangiopancreatography						●							
Endoscopic ultrasound						●							
Full-field digital mammography	●	●						●					
Image-guided radiation therapy	●	●		●		●		●	●		●		●
Intensity-modulated radiation therapy		●											●
Multislice spiral CT	●		●								●		
PET/CT scanner	●	●	●	●				●	●		●	●	●
Prosthetic and orthotic services												●	
Robotic surgery	●	●	●					●					●
Robot-assisted walking therapy												●	
Shaped-beam radiation		●											
Simulated rehabilitation environment												●	
Single-photon-emission CT	●		●						●				
Stereotactic radiosurgery	●	●		●	●	●		●	●		●		●
Transplant services		●	●			●				●	●		
Total Elements	**8**	**8**	**6**	**4**	**1**	**7**	**0**	**5**	**5**	**2**	**6**	**7**	**6**

● Included in the measure for the specialty.

*** Five measures are listed, but hospitals can receive up to six points in Cardiology & Heart Surgery because two points are possible for transplant services—one point for heart transplant services and one point for tissue transplant services.

To reduce the effect of outliers, we imposed a threshold on the volume. If a hospital's MA-adjusted volume is greater than a modified Z-score of 3, it is winsorized and replaced with the volume that corresponds to the minimum observed volume with a modified Z-score greater than 3.

The formula for the modified z-score is $0.6745(x_i - \tilde{x}) / (1.4826 * MAD)$, where:

x_i: Hospital's own value

$\tilde{x}$: The median across all hospitals

MAD: The median absolute deviation across all hospitals

Table 5 includes the thresholds created for each of the specialties.

Table 5. Winsorized Volume Thresholds by Specialty

Specialty	Winsorized Volume Threshold
Cancer	1,837
Cardiology, Heart & Vascular Surgery	12,614
Diabetes & Endocrinology	1,285
Ear, Nose & Throat	1,925
Gastroenterology & GI Surgery	4,666
Geriatrics	28,154
Obstetrics & Gynecology	1,597
Neurology & Neurosurgery	5,647
Orthopedics	3,631
Pulmonology & Lung Surgery	9,843
Urology	483

Outpatient Volume for Ear, Nose & Throat and Obstetrics & Gynecology

In recognition that a large proportion of care is provided on an outpatient basis, the rankings include certain outpatient procedural cases in the total volume for Ear, Nose & Throat and Obstetrics & Gynecology. To identify outpatient procedures in these specialties, we applied the Ambulatory Potentially Preventable Complications grouper (AM-PPC; 3M Health Information Systems) to Medicare hospital outpatient department claims data for 2019 to 2021. ***Table 6*** provides the list of Procedure Sub Groups (PSGs) for two specialties, respectively:

Table 6. List of PSGs for Obstetrics & Gynecology and Ear, Nose & Throat Outpatient Volume

Obstetrics & Gynecology		Ear, Nose & Throat	
PSG	PSG Description	PSG	PSG Description
44	Female Genital System Procedures	34	Facial and ENT Procedures
50	Hysteroscopy		

Volume measure for Rehabilitation

For the rehabilitation rankings, volume of care serves as a key indicator of quality. For the volume data, we utilize data from the IRF component of Care Compare (IRF Care Compare) website maintained by CMS. In addition, two key rehabilitation registries (UDSMR[†††] and eRehabData[‡‡‡]) allowed hospitals to opt into public reporting with U.S. News for the rehabilitation rankings through early January 20, 2023[§§§]. The volume measure focuses on the patient volume for certain conditions that are considered complex or difficult to treat in a rehabilitation setting, specifically stroke, traumatic brain injury, and traumatic spinal cord injury; for 2023 three additional volume categories were added from IRF Care Compare and where available from UDS and eRehabData including non-traumatic brain injury, non-traumatic spinal cord injury, and other neurological conditions. For hospitals that participate in public reporting, the rankings compare available volumes for each of the six conditions from CMS and the registries using the largest volume available for scoring purposes. Note that to qualify for use of registry data, a hospital had to appear in IRF Care Compare and meet the minimum volume requirement. For hospitals that have treated one or more cases but less than 11, we treat them as having a value of 10 for purposes of scoring. Each of these volume measures are scored separately relative to all other eligible hospitals

[†††] https://www.udsmr.org/

[‡‡‡] https://web2.erehabdata.com/erehabdata/index.jsp

[§§§] Note that U.S. News plans to continue working with both registries so that hospitals will be able to opt into public reporting in the future.

and given a weight of 3% for volume of traumatic injury patients or stroke, and 2% for patients with non-traumatic or neurological conditions; the six volume measures together represent a total of 15% of the overall ranking in rehabilitation.

Nurse Staffing

The nurse staffing index is a ratio that reflects the combined intensity of inpatient and outpatient nursing. The numerator is the total number of on-staff registered nurses (RNs), expressed as full-time equivalents (FTEs); for example, two half-time nurses are the equivalent of one FTE. Only nurses with an RN degree from an approved nursing school and current state registration are considered. The denominator is the adjusted average daily census of patients, a variable created by AHA for U.S. News.

The measure estimates the total amount of care devoted to both inpatients and outpatients by reflecting days of inpatient care plus the estimated volume of outpatients. This index gives more weight to inpatient care while recognizing that outpatient care represents most hospital visits. The components of this index are derived from the AHA database. As with volume, extreme values were similarly adjusted to reduce the influence of wide variation. Value exceeding a modified Z-score of 3 are set to the value corresponding to a modified Z-score of 3. The formula for the modified z-score is $0.6745(xi - \tilde{x}) / 1.4826*MAD$, where:

xi: Hospital's own value

$\tilde{x}$: The median across all hospitals

MAD: The median absolute deviation across all hospitals

The calculation includes a correction for hospitals that provide skilled nursing onsite and report a total that combines both inpatient and skilled nursing. The nursing FTEs associated with the skilled nursing were removed from the numerator and a corrected adjusted average daily census was used for the denominator. The corrected adjusted average daily census values for hospitals affected by this change were calculated by the AHA and provided directly to the project.

To address problems with missing values in the AHA dataset for several hospitals for the FTEN variable, which is the principal nursing FTE variable, the rankings impute missing FTEN values. The project selects hospitals that do not have extreme nurse staffing ratios (i.e., are not outliers) and imputes the value of FTEN using the current values of the following variables in the reference population: FTEN (Full time equivalent registered nurses reported), FTERN (Full time

equivalent registered nurses estimated), ADJADC (Adjusted Average Daily Census) and BDTOT (total hospital beds set up and staffed).

Note that the nurse staffing measure is not used in rehabilitation as there is no adequate measure of nurse staffing that can be specifically applied to rehabilitation facilities from the AHA data at the present time.

Trauma Center

In a past U.S. News survey of board-certified physicians, respondents ranked the presence of an emergency room and status as a Level 1 or Level 2 trauma care provider high on a list of hospital quality indicators. Physicians in nine specialties ranked trauma center status as one of the top five indicators of quality. Their recommendations and analyses showing a strong relationship with other quality factors supported inclusion of a trauma measure in Ear, Nose & Throat, Gastroenterology & GI Surgery, Cardiology, Heart & Vascular Surgery, Neurology & Neurosurgery, Orthopedics, Pulmonology & Lung Surgery, and Urology.

Two variables in the AHA Annual Survey Database provide the required data. Both must be answered. One variable indicates the presence of a state-certified trauma center in the hospital (as opposed to trauma services provided only as part of a health system or joint venture). Beginning with the 2023-2024 rankings, U.S. News piloted the use of public records to verify AHA's data for this variable for certain hospitals in two populous states, California and New York; hospitals did not receive credit in several cases where U.S. News determined the trauma center was associated with a different hospital's license. The second variable indicates trauma center level. The trauma center indicator is dichotomous. To receive credit of 1 point, a hospital must be a Level 1 or Level 2 trauma center[****]. The AHA defines Level 1 as "a regional resource trauma center, which is capable of providing total care for every aspect of injury and plays a leadership role in trauma research and education."[13] Level 2 is "a community trauma center, which is capable of providing trauma care to all but the most severely injured patients who require highly specialized care."[13]

Patient Services

Patient services encompass major conveniences for patients. Among others, they include translators, advanced or especially sophisticated care, and services either considered clinically essential in a comprehensive, high-quality hospital, such as cardiac rehabilitation, or reflective of

[****] The highest two levels of this designation are equivalent to the top two levels of the American College of Surgeons trauma center certification and can be used by hospitals in states that do not certify trauma centers.

forward thinking and sensitivity to community needs, such as genetic testing or counseling. All items are taken from the AHA Annual Survey.

Brief descriptions of patient services included in the index follow. The definitions are taken from the AHA Annual Survey of Hospitals (and expanded as necessary).

- **Alzheimer's center.** A facility that cares for individuals with Alzheimer's disease and the patients' families through an integrated program of clinical services, research and education. As with all items in this survey, each hospital determines whether the service is offered, based on the AHA description. This index differs from designation as an NIA Alzheimer's center, which is a higher-order designation and is treated as a separate structural measure in Geriatrics and in Neurology & Neurosurgery.

- **Arthritis treatment center.** A center specifically equipped and staffed for diagnosing and treating arthritis and other joint disorders.

- **Cardiac rehabilitation.** A medically supervised program to help heart patients recover quickly and improve their overall physical and mental functioning in order to reduce risk of another cardiac event or to keep a current heart condition from worsening.

- **Cardiac intensive care unit.** The unit is staffed with specially trained physicians and nursing personnel with specialty monitoring and support/treatment equipment for patients who, because of heart seizure, open-heart surgery, or other life-threatening conditions, require intensified, comprehensive observation and care.

- **Case management**. A system of assessment, treatment planning, referral and follow-up that ensures the provision of comprehensive and continuous services and the coordination of payment and reimbursement for care.

- **Employment support services.** Services designed to support individuals with significant disabilities to seek and maintain employment.

- **Enabling services**. A program that is designed to help the patient access health care services by offering any of the following: transportation services and/or referrals to local social services agencies.

- **Fertility clinic.** A specialized program set in an infertility center that provides counseling and education, as well as advanced reproductive techniques.

- **Genetic testing/counseling.** A service equipped with adequate laboratory facilities and directed by a qualified physician to advise parents and prospective parents on potential problems in cases of genetic defects.

- **Health research.** Organized hospital research program in any of the following areas: basic research, clinical research, community health research, and/or research on innovative health care delivery.

- **Hemodialysis.** Provision of equipment and personnel for the treatment of renal insufficiency on an inpatient or outpatient basis.

- **Hospice.** A program that provides care (including pain relief) and supportive services for the terminally ill and their families.

- **Infection isolation room.** A single-occupancy room designed to minimize the possibility of infectious transmission, typically through the use of controlled ventilation, air pressure, and filtration.

- **Neurological services.** Services provided by the hospital dealing with the operative and nonoperative management of disorders of the central, peripheral, and autonomic nervous systems.

- **Occupational health services.** Includes services designed to protect the safety of employees from hazards in the work environment.

- **Pain-management program.** A program that provides specialized care, medications or therapies for the management of acute or chronic pain.

- **Palliative care.** A program that provides specially trained physicians and other clinicians to relieve acute or chronic pain or to control symptoms of illness.

- **Patient-controlled analgesia.** A system that allows the patient to control intravenously administered pain medicine.

- **Patient education center.** Written goals and objectives for the patient and/or family related to therapeutic regimens, medical procedures, and selfcare.

- **Patient representative services.** Organized hospital services providing personnel through whom patients and staff can seek solutions to institutional problems affecting the delivery of high-quality care and services.

- **Physical rehabilitation outpatient services.** Program providing medical, health-related, therapy, social, and/or vocational services to help people with disabilities attain or retain their maximum functional capacity.

- **Psychiatric services - psychiatric consultation-liaison services.** Provides organized psychiatric consultation/liaison services to nonpsychiatric hospital staff and/or departments on psychological aspects of medical care that may be generic or specific to individual patients.

- **Psychiatry–geriatric service.** A psychiatric service that specializes in the diagnosis and treatment of geriatric medical patients.

- **Social work services.** Organized services that are properly directed and sufficiently staffed by qualified individuals who provide assistance and counseling to patients and their families in dealing with social, emotional, and environmental problems associated with illness or disability, often in the context of financial or discharge planning coordination.

- **Support groups.** A hospital sponsored program that allows a group of individuals with common experiences or issues who meet periodically to share experiences, problems, and solutions in order to support each other.

- **Translators.** A service provided by the hospital to assist patients who do not speak English.

- **Wound-management services.** Services for patients with chronic and non-healing wounds that often result from diabetes, poor circulation, sitting or reclining improperly, and immunocompromising conditions. The goals are to progress chronic wounds through stages of healing, reduce and eliminate infections, increase physical function to minimize complications from current wounds, and prevent future chronic wounds. Services are provided on an inpatient or outpatient basis depending on the intensity of service needed.

From seven to sixteen services are included in each specialty. Hospitals receive 1 point for each specified service provided on- or off-site either (1) by the hospital or its subsidiaries, (2) by the hospital's health system in the local community, or (3) by another institution in the local community through formal arrangement or joint venture. ***Table 7*** displays patient services by specialty.

Table 7. Patient Services by Specialty

Service	Cancer	Cardiology, Heart & Vascular Surgery	Diabetes & Endocrinology	Ear, Nose & Throat	Gastroenterology & GI Surgery	Geriatrics	Obstetrics & Gynecology	Neurology & Neurosurgery	Orthopedics	Pulmonology & Lung Surgery	Rehabilitation	Urology
Alzheimer's center						●		●				
Arthritis treatment center						●			●			
Cardiac rehabilitation		●										
Cardiac intensive care unit		●										
Case management											●	
Employment support services											●	
Enabling services											●	
Fertility clinic							●					●
Genetic testing/counseling	●		●	●	●		●	●		●		●
Health research											●	
Hemodialysis											●	
Hospice	●	●	●	●	●	●	●	●	●	●		●
Infection isolation room	●		●	●	●		●	●		●		●
Neurological services											●	
Occupational health services											●	
Pain-management program	●	●	●	●	●	●	●	●	●	●	●	●
Palliative care	●	●	●	●	●	●	●	●	●	●		●
Patient-controlled analgesia	●	●	●	●	●	●	●	●	●	●		●
Patient education center											●	
Patient representative services											●	
Physical rehabilitation outpatient services											●	
Psychiatry/geriatric service						●						
Psychiatric services - psychiatric consultation-liaison services											●	
Social work services											●	
Support groups											●	
Translators	●	●	●	●	●	●	●	●	●	●	●	●
Wound-management services	●	●	●	●	●	●	●	●	●	●	●	●
Total Elements	**8**	**8**	**8**	**8**	**8**	**9**	**9**	**9**	**7**	**8**	**16**	**9**

● Included in the index for the specialty.

ICU Specialists

ICU specialists are board-certified physicians with subspecialty or fellowship training in critical-care medicine. They specialize in managing critically ill patients in hospital intensive care units (ICUs). Recent research indicates that better outcomes are associated with the presence of ICU specialists.[14,15] The rankings award 1 point to hospitals with at least one ICU specialist FTE, whether on staff or through another arrangement as long as at least one ICU specialist serves in an adult-focused intensive care unit setting within the hospital. Previously hospitals had to have at least one FTE on staff ICU specialist. Credit was determined from the FY2021 AHA Annual Survey.

External Organizations

The following describes sources and organizations other than AHA and CMS that provided data for additional structural measures.

NCI-Designated Cancer Center

The National Cancer Institute (NCI), an arm of the National Institutes of Health, is the principal federal agency tasked with conducting and sponsoring cancer research and training and promoting research and standards of care by various means, including certification as an NCI-designated cancer center. Such a center is committed to advancing cancer research and, ultimately, reducing cancer incidence and increasing the effectiveness of treatment.[12]

NCI-designated centers have three classification levels. The lowest is *basic cancer center*, denoting a facility that conducts a high volume of advanced federally funded laboratory research. Credit is not awarded for this designation. A *clinical cancer center*, the second level, adds clinical ("bench-to-bedside") research. *Comprehensive cancer center*, the highest level, adds prevention research, community outreach, and service activities.[16]

Hospitals designated as NCI clinical or comprehensive cancer centers (and their official consortium partners) as of February 2, 2023, were awarded 1 point. Hospitals designated "*basic cancer centers*" did not receive credit. NCI updates the list throughout the year. The current list is at http://cancercenters.cancer.gov/Center/CCList.

Nurse Magnet Status

The Nurse Magnet measure is a formal designation by the Magnet Recognition Program®. The Magnet Recognition Program was developed by the ANCC to recognize health care organizations that meet certain quality indicators on specific standards of nursing excellence. The

ANCC updates the list of Magnet-recognized facilities throughout the year as organizations apply for designation and re-designation status. U.S. News bases credit for this measure on Magnet Recognition as of December 13, 2023. U.S. News is not responsible for any omissions in the data made available by ANCC. The current list of Magnet-recognized organizations is shown at https://www.nursingworld.org/organizational-programs/magnet/find-a-magnet-facility/.

Hospitals received 1 point for being recognized as a Nurse Magnet hospital. For hospitals that are part of a special merger†††† or a multi-campus hospital, the primary hospital (usually the larger of two or more general acute-care hospitals) is required to have Magnet Recognition status for the combination hospital to receive 1 point.

NAEC-Designated Epilepsy Center

One point was awarded to hospitals designated by NAEC as Level 4 epilepsy centers as of April 3, 2023. A Level 4 epilepsy center serves as a regional or national referral facility. These centers provide more complex forms of intensive neurodiagnostic monitoring, as well as more extensive medical, neuropsychological, and psychosocial treatment. Level 4 centers also offer a complete evaluation for epilepsy; surgery, including intracranial electrodes; and a broad range of surgical procedures for epilepsy.[17] NAEC updates its list of hospitals throughout the year. The current list is shown at http://www.naec-epilepsy.org/find.htm.

NIA-Designated Alzheimer's Center

Evaluation and certification are conducted by NIA, an arm of NIH that translates research advances into improved diagnosis and care of Alzheimer's disease and conducts research on prevention and cures. Recognition means that a hospital has received significant funding for and conducts research on Alzheimer's disease as well as providing a high level of care for Alzheimer's patients. Hospitals designated as an NIA Alzheimer's center as of January 12, 2023, received 1 point. Hospitals listed as affiliated centers did not receive credit. The current list of NIA Alzheimer's centers can be accessed at https://www.nia.nih.gov/health/alzheimers-disease-research-centers.

FACT Accreditation

This designation indicates that as of January 27, 2023, a hospital met standards set by FACT for transplanting bone marrow or other cellular tissue to treat cancer. Two points were given if

†††† In a special merger, two separate hospitals operate as one and their data are combined for analysis. Brigham and Women's Hospital and Dana-Farber Cancer Center are an example in Cancer. Specialty or secondary hospitals that are combined with the primary hospital are noted on the U.S. News website for that hospital.

accreditation was for *allogeneic transplants,* involving cells donated by another person (allowing for a greater number and more kinds of cell transplants), regardless of other accreditations. If a hospital did not have allogeneic transplant accreditation, but they did have accreditation for either *autologous transplants*, in which a patient's own cells are removed and then returned following radiation therapy, or for *immune effector cellular therapy (IECT),* they received one point. The current list of FACT-accredited hospitals can be accessed at www.factwebsite.org.

CARF Accreditation

Accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF International) designates a center as meeting standards of excellence in rehabilitation care. Data was obtained from CARF International on January 27, 2023. The current list of CARF accredited hospitals can be accessed at http://www.carf.org/providerSearch.aspx. In the rehabilitation specialty, this accreditation is worth a total of 2.5%. Additionally, the U.S. News website notes which hospitals had certain specialty certifications from CARF International.

Rehabilitation Model Systems

Designation as a Model Systems in Rehabilitation by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR; see https://msktc.org/) indicates that a center has received federal funding to advance rehabilitation care through innovative research. Designations are available in the areas of Spinal Cord Injury (SCI), Burns (BMS), and Traumatic Brain Injury Model Systems (TBIMS). Facilities received credit if they had one or more model systems designations awarded by NIDILRR. Data for this element was obtained from NIDILRR on February 6, 2023. The model systems designation is worth a total of 2.5% of the ranking. Additionally, all hospitals with model systems designation received the 2.5% associated with CARF accreditation, whether or not they were accredited by CARF International (for a total of 5% of their score in the rehabilitation specialty).

Normalization

All structural measure values were normalized prior to weighting. Normalization transforms index values into a distribution between 0 and 1 based on the range of possible values for a given measure. Normalizations were done separately for each specialty. Equation (1) is the formula for normalization:

$$Normalized\ Value = (X_i - Minimum_i) / (Maximum_i - Minimum_i), \quad (1)$$

where

X_i = the value for measure i,
$Maximum_i$ = the highest possible value for measure i and
$Minimum_i$ = the lowest possible value for measure i.

For example, the Advanced Technologies index for Cancer is worth a maximum of 8 points. If a given hospital received 5 out of 8 points, the normalized value for the Advanced Technologies index in Cancer would be (5-0)/(8-0) = 0.63. For all structural measures, other than Number of Patients and Nurse Staffing, the lowest *possible* value is 0 even when the lowest *observed* value is greater than 0. For Number of Patients and Nurse Staffing, the lowest possible value was made equal to the lowest observed value and the highest possible value was made equal to the highest observed value.

Weighting

In 2012, we convened an expert panel to determine appropriate weights for each of the measures. The evaluation was done both across specialties for consistency in weighting and within specialties to identify key measures of quality in a particular specialty. Overall, weights were determined based on the importance of each measure in defining the overall structural attributes of care within hospitals. Weights for Rehabilitation, a specialty that was not discussed by the expert panel, were assigned by the project team after considering input from diverse stakeholders. ***Table 8*** shows the weight for each of the measures that make up the structural component of the rankings, by specialty. These weighted scores are used in the calculation of the overall raw score in ***Section II.G Calculation of the Overall Score for the Data-Driven Specialties***. For all specialties, the sum of the weights is 35%, the overall weight for the structural component of the overall score.

Table 8. Structural Elements and Percentages (%) of Total Score by Specialty

Item	Cancer	Cardiology, Heart & Vascular Surgery	Diabetes & Endocrinology	Ear, Nose & Throat	Gastroenterology & GI Surgery	Geriatrics	Obstetrics & Gynecology	Neurology & Neurosurgery	Orthopedics	Pulmonology & Lung Surgery	Rehabilitation	Urology
Advanced technologies	5	5.83	6.18	5.83	5.83		6.18	4.77	5.83	5.83	7.5	5.83
CARF accreditation*											2.5	
FACT accreditation	3.33											
ICU specialists	3.33	3.89	4.12	3.89	3.89	4.12	4.12	3.18	3.89	3.89		3.89
NAEC-designated epilepsy center								3.18				
NCI-designated cancer center	3.33											
NIA-designated Alzheimer's center						6.18		3.18				
Number of patients	6.67	7.78	8.24	7.78	7.78	8.24	8.24	6.36	7.78	7.78	15	7.78
Nurse Magnet status	3.33	3.89	4.12	3.89	3.89	4.12	4.12	3.18	3.89	3.89		3.89
Nurse staffing	6.67	7.78	8.24	7.78	7.78	8.24	8.24	6.36	7.78	7.78		7.78
Patient services	3.33	3.89	4.12	3.89	3.89	4.12	4.12	3.18	3.89	3.89	7.5	3.83
Rehabilitation model systems*											2.5	
Trauma center		1.94		1.94	1.94			1.59	1.94	1.94		1.94

* All hospitals with model systems designation received the 2.5% associated with CARF accreditation, whether or not they were accredited by CARF International (for a total of 5% of their score in the rehabilitation specialty).
Note: Percentages may not sum to 35 due to rounding.

C. Outcomes

The correlation between quality of care and risk-adjusted outcomes is self-evident and supported by the literature.[18-32] Outcomes, which include specialty-specific, risk-adjusted mortality rates and rates of discharge to home, are worth 45% of the overall score in most specialties. Some specialties also include a measure of complications following outpatient surgeries and other outpatient procedures. Rehabilitation includes a unique set of outcome measures, described below.

When comparing outcomes such as mortality between hospitals, adjusting for differences in the patients treated at each hospital is critical. These adjustments need to take into account not only the principal condition for which the patient is being treated but also other comorbidities and characteristics that may affect outcomes. For instance, a hospital with a 35% death rate might be superior to a hospital with a 10% death rate, if most of the patients at the first hospital are of high risk (i.e., expected to die) and most of the patients at the second hospital are of fairly low risk.

To address the differences in risk, we used multilevel logistic regression models to adjust for differences in case mix between hospitals. Multilevel models are a form of regression that allocates variance between variables on two or more levels. We used the empirical Bayes estimate of the hospital intercept as an estimate of each hospital's value for a given outcome. Multilevel modeling accounts for clustering of patient observations within hospitals and allows for more precise evaluation of hospitals with lower patient volume and fewer outcomes.

We selected covariates for inclusion in risk-adjustment models based on the literature, discussions with clinicians in relevant specialties and experience. The model indicates that an unbiased estimate of the effect of treatment at a given hospital as compared to a hospital selected at random from among those eligible for ranking with a specialty, requires adjustment for age, sex, Elixhauser comorbidities,[33] socioeconomic status (SES), and year of admission. We have controlled for severity of index condition via restriction of cases consistent with the subset of DRGs used by the project as described at the end of this section and ***Appendix B***.

For the analyses we used pooled SAF data from CY2019, CY2020, and CY2021, the latest available for analysis. SAF data are derived from reimbursement claims submitted by hospitals to Medicare. The SAF data files contain information on all fee-for-service Medicare patients' diagnoses, procedures, length of stay in the hospital and discharge status. Only patients 65 years of age or older at the time of care were included in the analyses.

The SAF data include the CMS DRG assigned to each case for Medicare payment. Each SAF data record contains information on the patient's diagnosis, surgery (or other medical procedure), age, sex, and discharge destination.[34] DRGs classify the *International Classification of Diseases, Tenth Revision* (ICD-10) diagnosis codes into more meaningful patient groups based on clinical and cost similarity.[36]

Because MS-DRGs are relatively homogeneous groups of diagnoses and procedures, we use MS-DRGs as the basic unit for defining cases to be included in each specialty's outcome and volume measures (see ***Appendix B*** for the MS-DRGs used). MS-DRGs that represent challenging and/or

critical procedures were preferentially included. The process used to identify MS-DRGs is outlined below.###

1. MS-DRGs for very-low-intensity cases were excluded.
2. MS-DRGs that generally do not apply to a Medicare or elderly population were excluded.
3. Excluded and included MS-DRGs were evaluated on their embedded diagnoses.
4. Excluded and included categorizations were refined based on within-MS-DRG variation in diagnostic complexity.
5. MS-DRGs not assigned to a specific specialty were evaluated to determine whether they should be categorized more specifically.
6. MS-DRGs were attributed to multiple specialties if patients assigned to the DRGs are commonly treated by physicians in multiple specialties, or specific diagnoses or procedures were assigned to specific specialties based on principal diagnosis or procedures.
7. A final evaluation for clinical consistency was performed.

Outcome Methodology

Changes over the years have addressed specific issues in calculating mortality. These changes have addressed either specialty-specific issues (such as defining a specific population to use in Geriatrics as opposed to using all cases) or more general issues that can affect mortality outcomes (such as excluding transfers). Brief descriptions of these special considerations are provided below.

1. Redefining the Geriatrics patient population. Rankings in Geriatrics were dropped in 2006 but reintroduced in 2007, using a new approach to identify the target population and account for their mortality rates. Rather than using a small subset of MS-DRGs typical of geriatric patients, we elected to focus on how well hospitals treat older patients across a wide range of MS-DRGs. The Geriatrics specialty rankings now include all MS-DRGs generally appropriate to a Medicare or elderly population, but for the outcomes analysis only patients who are at least 75 years of age are included. The basic outcomes analyses of the data for this group followed the same procedures as for the other data-driven specialties.

2. Excluding transfers from mortality calculations. Since 2007, all patient transfers into the hospital have been excluded from mortality calculations. This was done to help avoid mortality

For a more detailed review of these procedures, see the 2005 Best Hospitals Ranking Methodology Report at www.rti.org/besthospitals.

rates that might be inflated by transfers of severely ill patients to tertiary care hospitals. Research has shown that because of their location, some tertiary care hospitals are particularly vulnerable to "dumping."[37] This change means that patients legitimately transferred for appropriate care are lost to analysis, but it is more important to ensure that each hospital's mortality numbers are not affected by transfers of very sick patients from hospitals unable to properly care for them. Transfers were identified using the claim source of inpatient admission variable and the patient discharge status code on the inpatient SAF data files. The variable value of "4" (Transfer from hospital (Different Facility) where he or she was an inpatient) was used to identify explicit inbound transfers, except in instances where the record from the preceding hospitalization was inconsistent with a transfer. Additionally, patients who are discharged and then admitted to a different hospital within one day were considered transfers.

3. Standardizing on 30-day mortality. Prior to 2007, mortality in the Best Hospitals methodology was defined as the rate of inpatient deaths (i.e., those occurring from admission to discharge). As inpatient hospital length of stay has decreased, inpatient mortality has generally decreased as well. Mortality over longer periods post-discharge, however, has not declined markedly.[38] Quality of care in the inpatient setting can affect patients' health and functional status for many weeks following discharge. AHRQ states in *Refinements of the HCUP Quality Indicators Technical Summary* (2001) that "without 30-day mortality data (ascertained from death certificates), hospitals that have short lengths of stay may appear to have better patient outcomes than other hospitals with equivalent 30-day mortality."[39]

Thirty-day mortality may reflect factors unrelated to care provided in the hospital (e.g., quality of post-acute care and lack of patient compliance with treatment regimen). Inpatient mortality, on the other hand, omits factors that tend to manifest in full after patients have been discharged. Inpatient mortality also does not account for hospital-to-hospital differences in length of stay for comparable patients and conditions.

To address these concerns, the 2007 rankings introduced 30-day mortality (i.e., 30 days post admission) for all specialties except Cancer. This exception was made because of concern that 30-day mortality might penalize hospitals that see large numbers of cancer patients at the end of life—thus artificially inflating their mortality numbers. After further review of available data and research, however, we concluded that 30-day mortality should be consistent. Starting in 2008, 30-day mortality has been used for all data-driven specialties.[§§§§]

[§§§§] Note that the mortality methodology does not exclude palliative care (V66.5) or hospice cases due to significant inconsistencies in the way in which palliative and hospice care services are documented, defined, and coded across providers. The analyses rely on the MS-DRG system to account for patient severity and risk of mortality in the SAF data rather than removing these cases from analyses.

4. Adjustment for socioeconomic status and risk. Starting in the 2017-18 rankings, a new adjustment was included at the patient level for Medicare and Medicaid dual eligibility. The dual-eligible flag is set to either 0 (not present) or 1 (present) for each case entering the risk-adjusted mortality equation. This was done to address known differences in morbidity and mortality with hospital patients associated with lower socioeconomic status (SES); dual-eligibility, or more specifically eligibility for Medicaid, is being used in this case to represent lower SES. The impact of the change was small and results in scores that better represent patient survival in the hospitals evaluated.

5. Update to the calculation of Survival and Discharge to Home. Starting with the 2019-2020 rankings, the project adopted a new risk-adjustment approach for the Survival and Discharge to Home outcomes that moves away from the observed to expected ratios (OER) to 'random effect' (RE) models, which can be thought of as a hospital level off-set. They represent the risk difference between a hospital and all hospitals in a given specialty, discounted by the reliability of that difference. The reliability is based on the volume of cases in a hospital, which means that if a hospital has 500 cases and 0 deaths, they would have a better RE, and thus better mortality score, than a hospital with 50 cases and 0 deaths; previously, these hospitals would have had the same OER of 0. The rationale for this is that in hospitals where there are more observations, there is higher certainty that the observed results are real and not due to statistical noise. The inclusion of information on certainty is the most important difference between the OER and the RE. A list and brief description of the covariates used in the risk-adjustment model is located in ***Table 9***.

To mitigate the impact of COVID-19-pandemic-associated disruptions on outcome measures, several exclusions were applied to visits occurring on or after March 1, 2020. First, visits in which a patient had a diagnosis of COVID-19 were excluded. Second, all visits occurring in March 2020 were excluded. Third, for each hospital, visits that occurred in April through December of 2020 were excluded if they occurred during a month in which the hospital's COVID-19 hospitalization rate exceeded the national average for that month or exceeded 15%, whichever was less. Any visits with a diagnosis of COVID-19 in 2021 (and onward) are not impacted by these exclusions. Instead, they are risk-adjusted in the outcomes statistical models. We do not exclude any visits with Covid-19 diagnosis when computing the volume.

Table 9. Covariates used for Risk-Adjustment of RE Models

Risk-adjustment variables	Description
Patient age at admission	Patient age as a linear variable
DRG roll-up	Rolled up DRG groups that include the variations w MCC, w CC, and w/o CC/MCC for medical and surgical treatment covered by the project (as shown in the tables in ***Appendix B***).
Sex	Male or female
Year of hospital admission	Quality of care tends to improve over time. This means the risk of adverse outcomes is less year to year. For that reason, year of admission is included as a risk factor.
Elixhauser comorbidities	We controlled for the 38 comorbidities identified by criteria from the Elixhauser Comorbidity Software Refined for ICD-10-CM (v2022.1) as being predictive of healthcare outcomes.
Medicare status code	The reason or reasons why the patient is eligible for Medicare: age, or age plus end-stage renal failure. This is a proxy for comorbidities.
Socioeconomic status	Patients with lower incomes are typically sicker when they arrive at the hospital and may face more challenges in obtaining or managing their care after they are discharged. This can affect their risk of death, readmission and complications. When hospitals differ by the socioeconomic status of their patients, this can create bias in comparing outcomes. Our risk models include "dual eligibility" as a measure of socioeconomic background. Patients who are eligible for both Medicare and Medicaid are treated as a separate risk group.
COVID-19 diagnosis	Patients diagnosed with COVID-19 in 2021 and onward

The accuracy of risk-adjustment models is measured by two statistics, the C-statistic and the Hosmer-Lemeshow goodness of fit statistic. The C-statistic estimates the probability that if one subject who experienced an outcome (death, for example) and another who did not are drawn randomly from the data, the model will assign a higher probability of death to the person who died. When interpreting the results of a C-statistic calculation, a value of .50 indicates the model has no better than random chance at predicting the outcome. A C-statistic in the .60-.69 range indicates limited discrimination, .70-.79 indicates acceptable discrimination and above .80 indicates good discrimination.

As shown in ***Table 10***, the C-statistic for risk-adjustment models implemented using clinical data range from approximately .75-.92. The new model for some of the outcome measures—Survival and Discharge to Home—were generally of similar predictive quality as those based on clinical data. The Hosmer-Lemeshow test assesses model goodness of fit within subgroups of the data and is generally not considered informative for samples over 25,000. We used a procedure designed to evaluate Hosmer-Lemeshow fit in large samples, in which multiple Hosmer-Lemeshow

tests are conducted on small samples of the data. A Hosmer-Lemeshow test results in a p-value, which below 0.05 indicates a bad fit; the closer to 1 the mean p-value is across all of the sample Hosmer-Lemeshow tests, the better fit. Overall, the results of the analyses show that the models have acceptable to good discrimination for all of the specialties.

Table 10. Predictive Accuracy of Risk-adjustment Models

	Survival		Discharge to home	
Specialty	C-statistic	Mean (min, max) of Large-sample Hosmer-Lemeshow Tests	C-statistic	Mean (min, max) of Large-sample Hosmer-Lemeshow Tests
Cancer	0.788	0.41 (0.05,0.90)	0.799	0.33 (0.00, 0.79)
Cardiology, Heart & Vascular Surgery	0.775	0.58 (0.05,0.92)	0.760	0.49 (0.18,0.99)
Diabetes & Endocrinology	0.797	0.38 (0.01,0.87)	0.752	0.52 (0.05, 0.89)
Ear, Nose & Throat	0.848	0.72 (0.53, 0.96)	0.815	0.38 (0.04,0.85)
Gastroenterology & GI Surgery	0.806	0.40 (0.09, 0.95)	0.768	0.47 (0.00,0.91)
Geriatrics	0.787	0.23 (0.01,0.64)	0.779	0.28 (0.03,0.50)
Neurology & Neurosurgery	0.799	0.62 (0.18,0.99)	0.792	0.38 (0.01,0.92)
Obstetrics & Gynecology	0.916	0.55 (0.17,0.88)	0.846	0.36 (0.01,0.78)
Orthopedics	0.861	0.67 (0.01,0.95)	0.880	0.43 (0.01,0.99)
Pulmonology & Lung Surgery	0.777	0.41 (0.00,0.99)	0.773	0.33 (0.03,0.89)
Urology	0.862	0.54 (0.15,0.84)	0.825	0.42 (0.02,0.84)

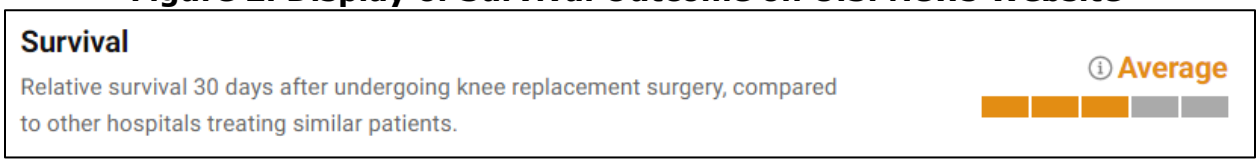
Additional analyses were conducted to evaluate the validity of the Best Hospitals rankings, as well as the component measures that are used to produce the rankings. In the Cardiology, Heart & Vascular Surgery specialty, we evaluated ranking differences between hospitals with heart transplant programs against those without. We performed similar analyses in the Cancer specialty (for bone marrow transplant centers) and Gastroenterology & GI surgery (liver transplant). We also looked at how hospitals with specialized AHA service codes performed on outcomes in related specialties (e.g., service code 41-cancer for the cancer specialty, service code 47-orthopedic for the orthopedics specialty, and service codes 13 and 42- surgical and heart for the cardiac specialty). Lastly, we performed similar analyses to understand whether hospitals operating trauma centers attained higher ranks in each specialty. In each case, the results of the risk adjusted mortality and discharge to home scores were consistent with expectations.

Survival Score

The rankings present mortality results through the use of a survival score. Survival scores are used to convey performance on outcome measures so that users of the rankings can quickly see how hospitals perform relative to each other. As described below, the survival (and discharge) scores represent a range of performance rather than a precise point estimate of performance based on the RE. This is used for display purposes in the rankings only.

We published survival scores as integer values ranging from 1 to 5. See an example of a survival score of 3, indicating performance not statistically different from expected, in *Error! Reference source not found.**Figure 2***.

Figure 2. Display of Survival Outcome on U.S. News Website



Our approach to determining each hospital's survival score falls under the general rubric of statistical significance testing. The cutoffs are different for each hospital. The survival score is reflective of a hospital's estimated risk-adjusted value (RE) on the outcome compared to other hospitals, as well as its Medicare claims volume and the incidence of that outcome. We compare each hospital's risk-adjusted outcome value to a normal distribution, taking into account precision as well as how a hospital compares to other hospitals—the greater a hospital's volume, the more certain we are of its estimated outcome value. For rare outcomes, such as death in Orthopedics, relatively few hospitals will have a rate that would designate it as above or below average. It is important to keep in mind that the bands displayed provide a heuristic for the RE, which is the underlying continuous metric that is used in calculating the rankings. Consequently, two hospitals with the same displayed survival score—but different underlying REs—may receive different rankings even if they have identical data on all other measures.

The display scores place hospitals into one of five scores reflecting their performance and our level of certainty about it. This takes into account the adjusted RE values along with measures of variability in the population of eligible hospitals to assign one of 5 groups based on how much they deviate from the mean. The center of the distribution, a score of 3, is defined as being less than 75% confidence in difference from the mean. A score of 4 represents hospitals that are better than average with 75% confidence and a score of 5 represents hospitals that are better than average with 90% confidence. Scores of 1 and 2 are the inverse of 5 and 4, respectively. Given that ranked

hospitals are a subset of all hospitals who generally perform better on patient outcomes, there will be more ranked hospitals with scores of 4 and 5.

Discharge to Home Score

The discharge to home measure assesses how well a hospital does at managing to discharge patients to home rather than sending them on to another acute or post-acute care setting following hospitalization. It is an outcome measure, not a measure of process. In other words, discharging patients with certain functional impairments to institutional post-acute care is appropriate from a process perspective. But in general, patients who are well enough to be discharged home have achieved better functional outcomes than patients who require discharge to an institutional care setting.

The denominator for this measure includes only patients who have been discharged following a qualifying inpatient admission; visits with inbound transfer status are excluded from the measure. The discharge status codes used in this measure come from the claims evaluated in the CMS SAF data. Hospitalizations with discharge status codes of 07 (left against medical advice or discontinued care), 20 (expired, did not recover - Christian Science), 21 (discharged to court/law enforcement), 30 (still a patient), 40 (expired at home, hospice claim), 41 (expired in facility, hospice claim), 42 (expired place unknown, hospice claim), 50 (home hospice), 62 (discharged/transferred to an IRF including distinct parts units of a hospital), or 87 (discharged to court/law enforcement with planned readmission) are excluded from the numerator and denominator, as are hospitalizations with a missing or invalid discharge status code and those with admission source code 8 (admitted upon direction of a court or law enforcement) or 5 (admitted from a nursing facility). Similarly, visits that were determined to have been admissions from a SNF, because in Medicare SNF claims data, the patient was observed in a SNF immediately prior to being admitted to a hospital, were excluded.

Discharge codes 01 (home/self-care), 06 (home with care of organized home health service organization), 81 (home/selfcare with planned readmission), and 86 (home with care of organized home health service organization with planned readmission) are included as a successful discharge to home. Discharge to a location other than home is indicated by one of the following patient discharge status codes: 02, 03, 04, 05, 09, 43, 51, 61, 63, 64, 65, 66, 69, 70, 82, 83, 84, 85, 88, 89, 90, 91, 92, 93, 94, 95.

Similar to the survival score, the discharge to home score was determined by statistical significance testing and is expressed as an integer from 1 to 5.

Prevention of Outpatient Complications for Orthopedics and Urology

This measure evaluates the ability of hospitals to prevent complications related to procedures conducted on an outpatient basis. In some surgical specialties, outpatient procedures have long been routine. In others, surgeries that historically involved admitting patients to an inpatient setting are now increasingly performed on an outpatient basis. To reflect the growing role of outpatient procedural care, measures of outpatient procedural outcomes were introduced in Orthopedics and Urology. (Analogous measures may be added to other specialties in future editions of the rankings.)

To identify outpatient procedures in these two specialties, potentially preventable complication rates for outpatient procedures were produced using the 3M Ambulatory Potentially Preventable Complications Grouper (AM-PPCs). We applied the Ambulatory Potentially Preventable Complications grouper software (AM-PPC; 3M Health Information Systems) to Medicare hospital fee-for-service outpatient claims and inpatient claims from 2019 to 2021. The AM-PPCs software assigns qualifying outpatient visits to one of several defined Procedure Sub Groups (PSGs), which are roughly analogous to DRGs but apply to outpatient procedures.

The AM-PPCs software also identifies potentially preventable complications, defined as a credible complication that can be attributed to the ambulatory procedure (e.g., infections, mechanical complications, bleeding/clotting, pneumonia/pulmonary, etc.) and is present on admission in a subsequent inpatient admission or emergency department visit that occurred within 30 days of an at-risk procedure. While AM-PPCs can also identify potentially preventable complications that present during post-procedural ambulatory encounters, the U.S. News measures did not include these events because of limitations in the completeness of the available Medicare data.

The measure evaluates the ability of hospitals to successfully perform procedures without complications using an observed to expected ratio of potentially preventable complications. Each hospital's observed complication count is calculated as the total number of outpatient procedures with a subsequent clinically relevant complication within 30 days across all PSGs assigned to the specialty. ***Table 11*** provides the list of PSGs assigned to the Orthopedics and Urology specialties.

Table 11. List of PSGs for Orthopedics and Urology Outpatient Outcomes

Orthopedics		Urology	
PSG	PSG Description	PSG	PSG Description
1	Shoulder and Elbow Arthroscopy Procedures	43	Male genital System Procedures
2	Hand and Wrist Arthroscopy Procedures	90	Extracorporeal Shock Wave Lithotripsy
3	Knee Arthroscopy Procedures	91	Lower Genitourinary Procedures
4	Hip Arthroscopy Procedures	93	Upper Genitourinary Procedures
5	Ankle Arthroscopy Procedures	94	Upper Genitourinary Stent and Guidewire Procedures
6	Foot Arthroscopy Procedures	95	Upper Genitourinary Catheter (Percutaneous) Procedures
7	Shoulder and Elbow Arthroplasty Procedures	101	Prostate Biopsy Procedures
9	Shoulder and Elbow Arthroplasty Revision Procedures		
10	Hand and Wrist Arthroplasty Procedures		
11	Hip Arthroplasty Procedures		
12	Hip Arthroplasty Revision Procedures		
13	Knee Arthroplasty Procedures		
14	Knee Arthroplasty Revision Procedures		
15	Foot and Ankle Arthroplasty Procedures		
16	Cervical Spine Fusion Procedures		
17	Cervical Spine Procedures		
18	Scalenus Procedures		
19	Lumbar and Sacral Spine Fusion Procedures		
20	Lumbar and Sacral Spine Procedures		
21	Thoracic Spine Fusion Procedures		
22	Thoracic Spine Procedures		
23	Open Hand and Wrist Procedures		
24	Open Shoulder Procedures		
25	Open Elbow Procedures		
26	Foot (Mid/Fore) Procedures		
27	Foot (Hind/Ankle) and Lower Leg Procedures		
28	Open Knee Fracture Repair and Ligament Procedures		
29	Other Knee and Soft Tissue Procedures		
30	Open Hip Fracture Repair and Other Bone Procedures		
31	Hip Extra-Articular and Soft Tissue Procedures		
32	Open Hip Intra-Articular Procedures		

To calculate the expected complication count for each hospital, each at-risk visit is first assigned a complication risk rate, which is calculated for each age group (65-74, 75-84, and 85+ years old) in each PSG assigned to the specialty. These complication risk rates are calculated by dividing the nationwide sum of all procedures with complications by the nationwide sum of all at-risk procedures within each age category and PSG group. Then, all complication risk rates for a given hospital in a given specialty are summed to generate the hospital-level expected complication counts for that specialty. Lastly, the observed complication count was divided by the expected complication count to generate a hospital-level, specialty-specific observed-to-expected ratio (OER).

Because OERs have a skewed distribution with a small number of extremely high values, OER values were winsorized at the 99th percentile of the OERs in each specialty before being normalized, weighted, and combined with the other outcome measures in the model. Raw PPC OERs range from 0 to a theoretical maximum of infinity, with lower values indicating better than expected performance, and higher values indicating worse than expected performance on the measure. However, for public display, we flip the direction of PPC OER values to match the orientation of other quality measures that we publish, in which higher values indicate better performance. We publish categorical values ranging from 1 to 5 based on the quintiles of the flipped OER values on each hospital's scorecard. These bands are meant to help users of rankings quickly compare how hospitals perform relative to each other.

Normalization and Weighting

As with structural measures, the outcome measures were normalized before being weighted and combined. The normalization formula can be found in ***Section II.B Structure***. Once normalized, the normalized survival and discharge to home values (and outpatient potentially preventable complications values) were weighted. These weighted scores are used in the calculation of the overall raw score in ***Section II.G Calculation of the Overall Score for the Data-Driven Specialties***. For all specialties, the sum of the weights is 45%, the overall weight for the outcomes component of the overall score. In Orthopedics and Urology, survival received a weight of 32%; discharge to home, 8%; and outpatient complications, 5%. In all other data-driven specialties except for Rehabilitation, survival received a weight of 36% and discharge to home a weight of 9%.

Outcomes for Rehabilitation

Death is not an informative outcome measure in rehabilitation care as the focus of care is patient functional improvement, community discharge and avoidance of future acute care where possible. This domain of the rankings is defined by outcomes available from IRF Care Compare including the following:

- Preventing potentially avoidable 30-day hospital readmissions after IRF discharge;
- Preventing potentially avoidable hospital readmissions during rehabilitation care; and
- Successful discharge to home and community.

Data from the two readmissions measures has been converted from a rate of readmissions to a rate of successful avoidance of readmissions while data from the discharge measure was taken as provided in IRF Care Compare. All three outcome measures are treated as continuous variables in order to maximize use of the information contained in the variable, and to minimize the risk of measurement error due to categorization. Each of these measures are worth 10%, for a total of 30% of the final ranking.

D. Process/Expert Opinion

The process/expert opinion component was worth 15% of the overall score in all specialties except for Cardiology, Heart & Vascular Surgery, Neurology & Neurosurgery, Obstetrics & Gynecology, and Pulmonology & Lung Surgery, in which it was worth 12%; and Rehabilitation, in which it was worth 35%, of which 30% was based on expert opinion and 5% on patient safety.

The process/expert opinion dimension of the Donabedian paradigm reflects care decisions in the hospital setting such as making choices about admission, diagnostic tests, course of treatment, choice of medication, and length of stay. It is extremely difficult to obtain national measurements of process. We contend that an appropriately qualified physician who identifies a hospital as among the "best" is, in essence, endorsing the process choices made at that hospital, and we regard the nomination of hospitals by board-certified specialists as a reasonable proxy measure.

To collect these nominations, a survey of board-certified physicians across the country is conducted each year. The rankings used nominations from the most recent 3 years of physician surveys (2021, 2022, and 2023). Scores were calculated separately in each year and averaged such that each year's scores are given equal weighting in the final expert opinion score as shown in ***Table 12.***

Table 12. 2021, 2022, and 2023 Expert Opinion Weights by Survey Year

Sample Source	Expert Opinion Weight (%)
2021 Physician Survey	33.3
2022 Physician Survey	33.3
2023 Physician Survey	33.3

The sections below describe the 2023 survey. The approaches used for the 2021 and 2022 surveys are described in the corresponding methodology reports for those years, available at www.rti.org/besthospitals.

Expert opinion scores were calculated in the same manner for both data-driven and expert opinion-based specialties. The following description therefore applies to both.

2023 Survey Approach

Sample Selection

The sample for the 2023 physician survey was selected from a database of all practicing U.S. physicians compiled by Doximity, the largest online professional network of U.S. physicians. Doximity's comprehensive Physician Database includes every practicing U.S. physician, identified by National Provider Identifier (NPI) number. Sources include the U.S. Department of Health and Human Services NPI Registry, state medical boards, and specialty boards (e.g., the American Board of Medical Specialties, the American Board of Surgery, and the American Osteopathic Association). Doximity's proprietary database is augmented by more than 750,000 registered and verified physician members who review and update their profiles to provide another set of primary data. U.S. News & World Report holds an equity interest in Doximity.

Table 13 provides the population counts of specialists in the Doximity database.

Data Collection Procedures

The Doximity member survey was sent to 352,233 physicians across the 15 specialties and was conducted from February to March 2023. Physicians received an initial email invitation with a link to the survey. The survey asked physicians to supply the names of up to five hospitals in their specialty that provide the best care to patients with serious conditions, without considering location or expense. Nonresponding physicians received one follow-up email reminder with a link to the survey. In addition, eligible Doximity members – i.e., those who were board certified in a relevant specialty – received alerts upon login to Doximity.com or use of the Doximity app inviting them to participate.

Table 13. Population Counts by Best Hospitals Specialty

Specialty	Subspecialties Included (based on board certification)	Doximity Members
Cancer	Hematology, gynecologic oncology, interventional radiology†, radiation oncology (ABMS and AOA) Medical oncology, complex general surgical oncology, surgical oncology, musculoskeletal oncology, therapeutic radiology (ABMS) Oncology, radiation therapy (AOA)	28,454
Cardiology, Heart & Vascular Surgery	Clinical cardiac electrophysiology, thoracic, cardiac, or cardiothoracic surgery§, interventional cardiology, vascular surgery, advanced heart failure and transplant, interventional radiology† (ABMS and AOA) Cardiovascular diseases, adult congenital heart disease, (ABMS) Vascular and interventional radiology† (AOA)	41,642
Diabetes & Endocrinology	Endocrinology, diabetes & metabolism (ABMS and AOA)	8,630
Ear, Nose & Throat	Otolaryngology, plastic surgery (Facial, Head, Neck) (ABMS and AOA)	12,403
Gastroenterology & GI Surgery*	Gastroenterology (ABMS and AOA) Colon and rectal surgery, transplant hepatology (ABMS)	32,496
Geriatrics	Geriatric medicine (ABMS and AOA)	12,134
Obstetrics & Gynecology	Obstetrics & gynecology (ABMS and AOA)	46,005
Neurology & Neurosurgery	Neurology, neurological surgery, neuroradiology, interventional radiology† (ABMS and AOA)	29,821
Ophthalmology	Ophthalmology (ABMS and AOA)	20,881
Orthopedics	Orthopedic surgery, sports medicine††, interventional radiology† (ABMS and AOA) Hand surgery (AOA)	30,639
Psychiatry	Psychiatry (ABMS and AOA) Geriatric psychiatry (AOA)	39,071
Pulmonology & Lung Surgery	Pulmonary diseases, thoracic surgery‡ (ABMS and AOA)	11,803
Rehabilitation	Physical medicine & rehabilitation, sports medicine†† (ABMS and AOA)	19,186
Rheumatology	Rheumatology (ABMS and AOA)	7,091
Urology	Interventional radiology† (ABMS and AOA) Urology (ABMS) Urological surgery (AOA)	11,977

† Interventional radiologists identified by the Society of Interventional Radiology as having >50% of clinical volume in this specialty area.
§ Except thoracic surgeons identified by U.S. News as subspecializing in surgical care of thoracic cancer
* General surgeons certified by the American Board of Surgery (ABMS) or Board of Surgery (AOA) identified by U.S. News as subspecializing in surgical care of gastrointestinal cancer were also eligible.
‡ Thoracic surgeons identified by U.S. News & World Report as subspecializing in surgical care of thoracic cancer.
†† Physicians board certified as sports medicine from the Board of Physical Medicine & Rehabilitation (ABMS or AOA) were eligible in Rehabilitation. All other sports medicine physicians were eligible in Orthopedics.

Response Rates

The overall response rate for the 2021, 2022, and 2023 surveys was 10.0% using American Association of Public Opinion Research (AAPOR) standard response rate 6,[*****] which treats undeliverables as ineligibles.

Of the 352,233 Doximity members identified as eligible in one of the 15 specialties, 31,315 completed the web survey. The final response rate was 8.9% using AAPOR standard response rate 2. ***Table 14*** shows response rates by region and specialty.

Table 14. Member Survey Response Rates by Region and Specialty, 2023

Specialty	Midwest (%)	Northeast (%)	South (%)	West (%)	Total (%)
Cancer	12.1	19.3	9.5	9.5	12.4
Cardiology, Heart & Vascular Surgery	11.0	14.9	8.0	7.2	10.1
Diabetes & Endocrinology	10.1	15.8	7.0	8.7	10.3
Ear, Nose & Throat	14.7	18.6	12.1	12.1	13.9
Gastroenterology & GI Surgery	8.6	12.8	5.5	6.0	7.9
Geriatrics	3.9	9.3	3.7	5.4	5.7
Obstetrics & Gynecology	5.0	10.9	3.1	3.6	5.2
Neurology & Neurosurgery	13.3	19.0	9.7	9.9	12.7
Ophthalmology	13.4	11.6	8.6	11.2	10.8
Orthopedics	6.7	14.6	5.1	4.5	7.1
Psychiatry	3.6	9.4	2.9	2.3	4.7
Pulmonology & Lung Surgery	12.6	16.3	9.0	7.7	11.2
Rehabilitation	12.0	13.8	7.2	8.3	10.0
Rheumatology	9.9	16.2	5.8	6.6	9.4
Urology	12.9	18.1	7.2	9.0	11.0
Overall Response Rate	**9.3%**	**14.0%**	**6.6%**	**6.7%**	**8.9%**

Note: Response rates are rounded.

[*****] Definitions are available online at http://www.aapor.org/AAPOR_Main/media/publications/Standard-Definitions20169theditionfinal.pdf

Survey Response Weighting

The weighting approach for the 2023 survey is described below. The approaches used for previous surveys are provided in the corresponding methodology reports for those years, which are available at www.rti.org/besthospitals.

For the 2023 Doximity member survey, we used post-stratification weights for age by gender (55+ male, <55 male, and female[†††††]) as well as census region. Weights were constructed and applied to each physician's survey response to make nominations representative of all Doximity members nationally. Since all Doximity members were surveyed, weights were used to adjust for differences in nonresponse only by region and demographics. Additionally, scores were adjusted based on a physician's current affiliation. Data from multiple sources were used to determine if a physician is currently affiliated with each hospital they nominated. Then certain adjustments were performed that result in nominations from unaffiliated physicians being weighted higher than those from physicians who have a current relationship with the hospital they nominated. The effect of these adjustments is to give higher weight to the opinions of unaffiliated physicians than to those of affiliated physicians, particularly in cases where a hospital received a relatively large proportion of its nominations from affiliated physicians. To ensure the integrity of the physician survey and weighting procedures for the Expert Opinion score, no additional methodological detail about this new adjustment will be made public.

Transformation

The rankings display weighted 3-year expert opinion values. Before incorporating the values into the scoring for the 12 data-driven specialties, however, the values were first capped at 25% (i.e., values exceeding 25% were set to 25%) and then log transformation was implemented to adjust for the skewed distribution. These transformations were not applied in the three expert opinion-based specialties.

By its nature, a survey that solicits recommendations for "bests" will generate data that do not follow a normal distribution. Relatively few hospitals will receive even one "best" recommendation. Of those that do, even fewer will receive a significant number. The distribution of responses will inevitably be highly skewed. Because outcome and structural data are not similarly skewed, expert opinion would have a disproportionate impact if the extreme skewness was not addressed.

[†††††] Age categories were collapsed for females because there were too few female physicians over 55 in the sample.

Log transformation in the data-driven rankings reshapes the distribution to match expert opinion data more closely to those of the other components. Transformation is applied to the weighted expert opinion data using the formula $log(R_X + 10) - 1$, where R_X is the weighted expert opinion score for hospital X. Adding a constant of 10 moderates the effect of the transformation.

The transformed data are then normalized. ***Figure 3*** demonstrates the impact of the transformation. Transformed expert opinion scores are higher than untransformed scores, but the impact is greater on low scores than on high scores, as illustrated by these examples:

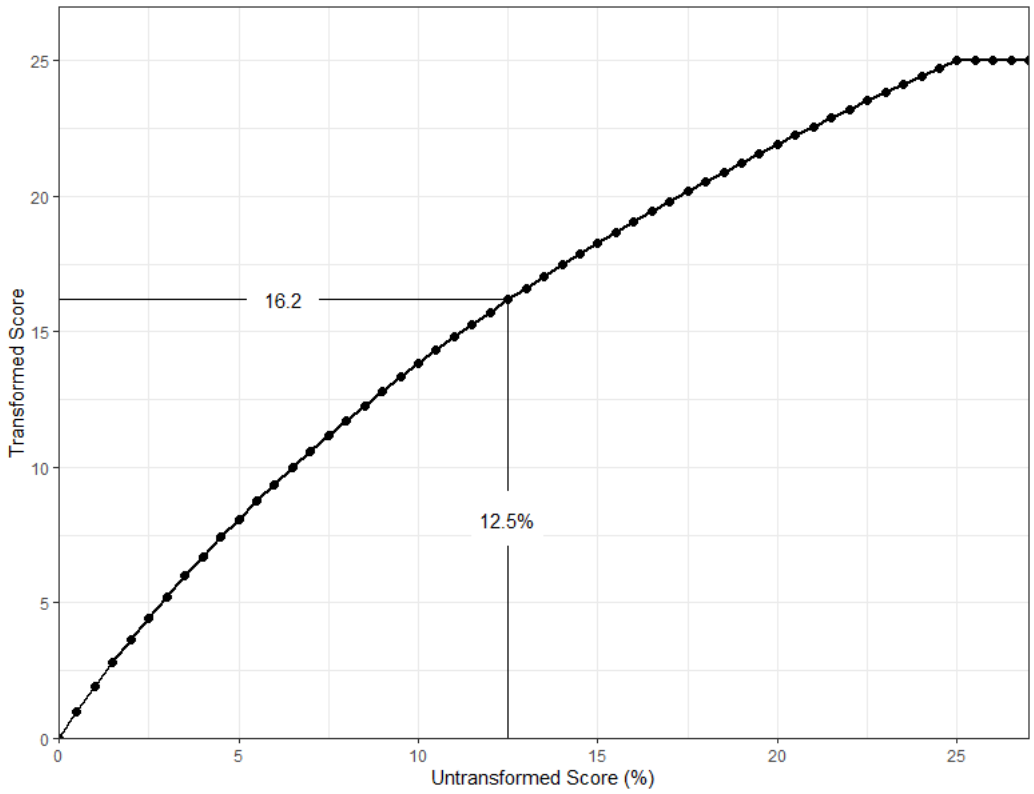
- An untransformed score of 1% has a transformed value of 1.9,
- an untransformed score of 12.5% has a transformed value of 16.2, and
- an untransformed score of 20% has a transformed value of 21.9.

Skewness is reduced, and the overall effect of the expert opinion score on hospitals' final standing in the rankings is diminished.

Normalization and Weighting

As with structural and outcome measures, expert opinion data were normalized before being combined with other metrics. Normalization transformed index values into a distribution between 0 and 1 based on a measure's range of *possible* (as opposed to observed) values between 0% and the previously mentioned cap at 25%. A hospital's normalized expert opinion score, after log transformation, was given a component weight of 12 in Cardiology, Heart & Vascular Surgery, Neurology & Neurosurgery, Obstetrics & Gynecology, and Pulmonology & Lung Surgery; 30 in Rehabilitation, and 15 in all other data-driven specialties. This weighted score is used in the calculation of the overall raw score in ***Section II.G Calculation of the Overall Score for the Data-Driven Specialties***.

Figure 3. Expert Opinion Data Before and After Transformation



Patient Safety (Rehabilitation)

A patient safety measure is drawn from IRF Care Compare and focuses on influenza vaccination rates of healthcare personnel, an important risk factor for patient safety within a healthcare setting. Data from this measure is treated as a continuous variable in order to maximize use of the information contained in the variable, and to minimize the risk of measurement error due to categorization. This measure is worth 5% of the final ranking.

E. Patient Experience Score

Starting with the 2019-20 rankings, the Best Hospitals Specialty Rankings include a patient experience score based on data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey[‡‡‡‡]. This measure was incorporated in response to feedback from patients, hospital leaders and other stakeholders about the importance of the patient experience when considering healthcare quality.

[‡‡‡‡]https://www.medicare.gov/hospitalcompare/Data/Overview.html

For this measure, a hospital's linear mean overall score from HCAHPS (variable name H_HSP_RATING_LINEAR_SCORE) will be used to calculate the patient experience score. The data file from HCAHPS used for the rankings is from April 1, 2021 (measure start date), through March 31, 2022 (measure end date). For the 11 cancer specialty hospitals exempt from the CMS Inpatient Prospective Payment System, analogous data from the PPS-exempt Cancer Hospital (PCH) HCAHPS dataset were used, if available. If a hospital had information from both sources, we used the PPS-exempt data for the Cancer specialty only. Otherwise, we used the information provided in either the standard HCAHPS or the PPS-exempt for all specialties. HCAHPS scores in both datasets could range from 0 to 100.

In Orthopedics, we introduced an adjustment to account for the fact that HCAHPS scores tend to be higher at specialty hospitals versus general acute-care hospitals. Based on our own research and feedback from the medical community, we believe this is due to different characteristics in the patient population and not wholly the result of different outcomes. The group mean adjustment we are introducing brings the mean HCAHPS scores at specialty hospitals closer to those at general hospitals to ensure that scores are comparable across hospital service categories. Our adjustment formula is as follows:

$$y_q = max\left(0, x_q - \left(\frac{1 - x_q}{1 - \overline{x_q}}\right) * \left(\overline{x_q} - \overline{x_p}\right)\right)$$

Where y_q and x_q refer to a specialty hospital's adjusted and unadjusted HCAHPS scores, respectively; x_q is the mean score at all specialty hospitals; and x_p is the mean score at all general hospitals. As a result of this adjustment, a specialty hospital with a perfect unadjusted score will receive a perfect adjusted score, whereas a specialty hospital with an unadjusted score equal to the mean score among specialty hospitals will receive an adjusted score equal to the mean score among general hospitals.

For hospitals with multiple Medicare Provider Numbers (MPN) in the standard HCAHPS data, we average their HCAHPS scores for inclusion in the rankings. If a hospital is missing entirely from the HCAHPS data, we rank the hospital in each specialty without regard to HCAHPS. This is done by first calculating the overall score in each specialty for all eligible hospitals minus the HCAHPS measure. Then, the overall score is computed for all hospitals with HCAHPS values (and including the HCAHPS measure). Finally, the overall score for hospitals missing HCAHPS is derived based on their overall score value from the first calculation (the score without HCAHPS). This ensures that their overall score in the version including HCAHPS aligns with their score in the version not including HCAHPS.

Note that while we use a weighted version of the HCAHPS scores in the overall rankings for each of the 12 data-driven specialties (see ***Section II.G Calculation of the Overall Score for the Data-Driven Specialties***), hospital profiles on usnews.com show the CMS star ratings as a score ranging from 1-5. The star ratings are easier for comparisons between hospitals by consumers and are more easily understood than the HCAHPS score. Note that in cases where multiple scores are available and have been averaged, we display the star value associated with the hospital's main MPN.

Note that patient experience data for rehabilitation facilities is not widely available, and the HCAHPS score is currently not incorporated into the rehabilitation rankings. We hope to be able to use a rehabilitation-specific CAHPS score and/or patient-reported outcomes in the future.

Normalization and Weighting

The patient experience scores are normalized before being combined with other metrics for the final ranking. The normalization formula is based on the theoretical minimum and maximum values of 0 and 100. This effectively results in the observed score being converted into a decimal between 0 and 1. A hospital's normalized patient experience score is then given a weight of 5 in all other data-driven specialties. This weighted score is used in the calculation of the overall raw score in ***Section II.G Calculation of the Overall Score for the Data-Driven Specialties***.

F. Public Transparency (Cardiology, Heart & Vascular Surgery, Obstetrics & Gynecology, Neurology & Neurosurgery, and Pulmonology & Lung Surgery)

Specialty-specific indicators of public transparency have been added to the rankings over time, as various clinical registries (or U.S. News itself) have commenced voluntary public reporting of relevant specialty-specific performance measures. Public transparency indicators are now part of the rankings in Cardiology, Heart & Vascular Surgery (added in 2016), Neurology & Neurosurgery (2020), Obstetrics & Gynecology (2022) and Pulmonology & Lung Surgery (2023).

For many years, clinicians in various medical specialties have collaborated with their counterparts at other hospitals to create clinical registries to foster quality improvement. More recently, public transparency has been identified as an important additional application for registry-based quality measurement. The Society of Thoracic Surgeons (STS) initiated voluntary public reporting for ACSD-participating hospitals in 2010. In 2015, the American College of Cardiology (ACC) began a similar program for two of the 10 registries that comprise the NCDR, the CathPCI Registry and the ICD Registry; it has since added public reporting from its Chest Pain-MI registry.

In 2019, the American Heart Association Get With The Guidelines (GWTG)[§§§§§] quality improvement programs started voluntary public reporting.

Transparency via clinical registries and other public transparency programs can facilitate informed decision making by patients, which in turn may boost patient engagement in their healthcare. Transparency also creates opportunities for researchers to externally validate or critically evaluate the results of hospital rankings such as Best Hospitals. Moreover, it demonstrates a public commitment on the part of the participating hospitals to the process of pursuing quality improvement.

Cardiology, Heart & Vascular Surgery

This measure rewards hospitals for voluntarily reporting cardiac-care performance data to the public through at least one of three important clinical registries: the National Cardiovascular Disease Registry (NCDR), which is maintained by the ACC; the Adult Cardiac Surgery Database (ACSD), maintained by the STS; and Get With The Guidelines (GWTG), maintained by the American Heart Association.

Hospitals received a score of 0 to 3 for participating in public reporting with ACC or GWTG and STS regardless of the specific ratings or performance scores each registry reported. For 2023-2024, a hospital got full credit for publicly reporting (a score of 3) if it reported data in the ACC and/or GWTG registries and also reported data in the STS registry. A hospital that reported data in STS but did not report in ACC or GTWG received 2 points; hospitals that reported in ACC and/or GWTG but not STS also received 2 points. Hospitals received zero points if they did not publicly report from any of these three registries. Only publicly reporting from these three registries earned hospitals a score on the measure. Hospitals that submitted data to these registries but did not allow the information to be made public did not receive credit. No normalization or weighting was done to this measure. The final public transparency score is used in the calculation of the overall raw score in ***Section II.G Calculation of the Overall Score for the Data-Driven Specialties***.

Details of Participation Requirements (ACC)

To receive credit for ACC public reporting, hospitals must have participated in either the ICD Registry, the CathPCI Registry, and/or the Chest Pain-MI Registry and voluntarily agreed to allow data from these registries to be posted on the ACC registry website, www.CardioSmart.org. To

[§§§§§] https://www.heart.org/en/professional/quality-improvement/get-with-the-guidelines/get-with-the-guidelines-stroke/get-with-the-guidelines-stroke-overview

receive credit, the hospital had to have a public reporting status of "Participating with ACC" for at least one of those registries as of December 5, 2022.

Details of Participation Requirements (STS)

To receive credit for STS public reporting, STS Adult Cardiac Surgery Database participants had to have their scores and data publicly displayed on the STS website (http://www.sts.org) as of December 23, 2022. STS ACSD public reporting currently includes outcomes for the following surgeries:

- Coronary artery bypass graft (Isolated CABG)
- Aortic valve replacement (Isolated AVR)
- AVR plus CABG surgeries (AVR+CABG)

Details of Participation Requirements (American Heart Association)

To receive credit for American Heart Association public reporting, hospitals must have participated and agreed to publicly report their data in at least one of the following Get With The Guidelines registries:

- GWTG - AFib
- GWTG - Coronary Artery Disease
- GWTG - Heart Failure
- GWTG - Resuscitation

A hospital's data must have been displayed on the American Heart Association publicly reporting website (https://qualitynearme.heart.org/GWTGPublicReporting) as of August 31, 2022 to be awarded credit for these registries.

Obstetrics & Gynecology

The transparency measure rewards hospitals for voluntarily reporting maternity care volume, outcomes, and structural program data on the annual U.S. News Maternity Services survey. Hospitals received a score worth 3% of their total ranking for this metric, if they completed the U.S. News Maternity Care survey during the prior calendar year. No normalization or weighting was done to this measure.

Neurology & Neurosurgery

The transparency measure rewards hospitals for voluntarily reporting stroke care to the public through the Get With The Guidelines (GWTG-Stroke) quality improvement program from the American Heart Association. To receive credit, hospitals had to submit an opt-in form to the GWTG-Stroke registry by August 31, 2022. Hospitals received a score of 3 points for participating in public reporting, while hospitals that did not choose to be transparent through GWTG-Stroke received no credit. No normalization or weighting was done to this measure.

Pulmonology & Lung Surgery

The transparency measure rewards hospitals for voluntarily reporting Lobectomy data via the Society of Thoracic Surgeons (STS) General Thoracic Surgery Database (GTSD) quality improvement program. To receive credit, hospitals had to submit an opt-in form to the registry by December 31, 2022. Hospitals received a score of 3 points for participating in public reporting, while hospitals that did not choose to be transparent through STS GTSD received no credit. No normalization or weighting was done to this measure.

The final public transparency score is used in the calculation of the overall raw score in ***Section II.G Calculation of the Overall Score for the Data-Driven Specialties***.

G. Calculation of the Overall Score for the Data-Driven Specialties

All Specialties (Excluding Cardiology, Heart & Vascular Surgery, Obstetrics & Gynecology, Neurology & Neurosurgery, Pulmonology & Lung Surgery, and Rehabilitation)

The U.S. News ranking score reflects the following weights for each of the major components:

- Structure = 35%
- Process/expert opinion = 15%
- Outcomes = 45%
- Patient experience = 5%

Individual measure weights can be found in the component specific sections above.

Rankings by U.S. News score for the top 50 hospitals in each specialty are shown in ***Appendix D***. Hospitals were recognized as High Performing in a specialty, for the Best Regional Hospitals lists, if they were not ranked in the top 50 but they received a score in the top 10 percent of all hospitals receiving a score in that specialty.

Equation (2) shows the formula for calculating the raw overall score for each specialty. A hospital's raw score in a specialty can be thought of as a simple sum of the four weighted ranking components, as shown below:

$$Raw\ score = \{\left(\sum_{i=1}^{n_s} S_i\right) + P + \left(\sum_{i=1}^{n_o} O_i\right) + PE\}, \quad (2)$$

where

S_i = normalized and weighted value for structural measure *i,*

P = normalized and weighted value for process/expert opinion score,

O_i = normalized and weighted value for outcomes measure *i,*

PE = normalized and weighted hospital-wide patient experience score.

This formula is illustrative only. It *cannot* be used to calculate the U.S. News score for an individual hospital or replicate a published score.

For presentation purposes, raw scores were transformed to a scale that assigns a U.S. News score of 100 to the top hospital. The formula for the transformation is shown in Equation (3):

$$U.S.\ News\ Score = (raw\ score - minimum)/range. \quad (3)$$

Cardiology, Heart & Vascular Surgery, Obstetrics & Gynecology, Neurology & Neurosurgery, and Pulmonology & Lung Surgery

For Cardiology, Heart & Vascular Surgery, Obstetrics & Gynecology, Neurology & Neurosurgery, and Pulmonology & Lung Surgery, the U.S. News score included a fifth component—public transparency—which accounts for 3% of the overall score. To accommodate this component, process/expert opinion weight was reduced to 12%. The U.S. News score for these four specialties reflects the following weights for each major component:

- Structure = 35%
- Process/expert opinion = 12%
- Outcomes = 45%

- Patient experience = 5%
- Public transparency = 3%

The formula for calculating the raw score for these four specialties is shown in Equation (4), as shown below:

$$Raw\ score = \{\left(\sum_{i=1}^{n_s} S_i\right) + P + \left(\sum_{i=1}^{n_o} O_i\right) + PE + PT\}, \quad (4)$$

where

S_i = normalized and weighted value for structural measure *i,*

P = normalized and weighted value for process/expert opinion score,

O_i = normalized and weighted value for outcomes measure *i*,

PE = normalized and weighted hospital-wide patient experience score,

PT = public transparency score.

As with the other specialties, raw scores were transformed to a scale that assigned a score of 100 to the top hospital.

Rehabilitation

For inpatient Rehabilitation, the U.S. News score represents a mix of structure, process (including patient safety), and outcomes but does not include patient experience or public transparency at this point in time. Given the fact that the Rehabilitation specialty was defined solely by expert-opinion prior to the 2022-2023 ranking, a higher weight for this component has been used to maintain the continuity with past rankings. For the 2023-2024 rankings, the expert-opinion measure is worth 35% of the total ranking. The other measures have been adjusted to reflect the availability and quality of the measures currently available.

The U.S. News score for Rehabilitation ranking reflects the following weights for each major component:

- Structure = 35%
- Process (including expert opinion and patient safety) = 35%
- Outcomes = 30%

The formula for calculating the raw score for Rehabilitation is shown in Equation (5), as shown below:

$$Raw\ score = \{\left(\sum_{i=1}^{n_s} S_i\right) + P + \left(\sum_{i=1}^{n_o} O_i\right)\}, \quad (5)$$

where

S_i = normalized and weighted value for Rehabilitation structural measure *i,*

P = normalized and weighted value for Rehabilitation process/expert opinion score,

O_i = normalized and weighted value for Rehabilitation outcomes measure *i.*

As with the other specialties, raw scores were transformed to a scale that assigned a score of 100 to the top hospital.

Adjustments for Missing IRF Care Compare Data

For hospitals that meet the eligibility requirements but do not have IRF Care Compare data, such as certain long-term acute-care hospitals and IRFs located in Maryland, which are exempt from CMS's standard IRF reporting requirements, the rankings used a modeling technique to rank each facility without regard to the missing IRF Care Compare data. This is done by calculating the overall rehabilitation U.S. News Score two different ways. First, an overall score was calculated for all eligible hospitals (including those missing the IRF Care Compare measures) using a measure weight of zero for all IRF Care Compare measures and the measure weights described above for all other measures. Then, the overall score was computed again for all hospitals that have IRF Care Compare data, this time using the measure weights above for all measures, including those derived from IRF Compare. Finally, the overall score from the first calculation was used as the U.S. News Score for hospitals that are missing IRF Care Compare data, and the overall score from the second calculation is used for hospitals that have IRF Care Compare data. This ensures that eligible hospitals missing key data points are ranked relative to other rehabilitation hospitals only on the basis of the data available for all rehabilitation hospitals.

III. Expert Opinion-Based Specialties

Available data for the three expert opinion-based specialties are significantly limited. Life-threatening conditions and procedures are more uncommon in ophthalmology and psychiatry, rendering mortality irrelevant as a primary outcome. Inpatient volume in rheumatology is also extremely low, making calculation of mortality unreliable. Reliable structural measures also are unavailable in these three specialties in most cases. Therefore, expert opinion alone determines the ranking in these specialties. This section describes the eligibility and procedures used to develop the rankings for these three specialties.

A. Eligibility

In specialties driven solely by expert opinion, hospitals have never had to meet the same eligibility standards as in the data-driven specialties. Ranked hospitals are those with an expert opinion score of at least 5% across the last 3 years. Hospitals with a score of at least 3% and less than 5% are recognized as High Performing in the Best Regional Hospitals lists. Hospitals with a score of at least 1% are considered eligible and are listed in the specialty directory on the U.S. News website.

B. Process/expert opinion

The data-driven specialties and expert opinion-based specialties share the same process/expert opinion component (see ***Section II.D Process/Expert Opinion*** for more information).

C. Calculation of the Rankings

As described above, scores for the expert opinion-based specialties of Ophthalmology, Psychiatry, and Rheumatology must be calculated differently from scores for the data-driven specialties because of the unavailability of structural and outcomes measures. Thus, we rank hospitals in these specialties solely by expert opinion (see ***Appendix E***).

IV. Number of Ranked Hospitals

This year, 164 different hospitals were ranked in at least one data-driven or expert opinion-based Best Hospitals specialty. Another 16 specialty hospitals that closely coordinate care with a partner hospital shared one or two specialty-specific rankings with that partner.

V. Honor Roll & Best Regional Hospitals

The Honor Roll since 1990 has recognized excellence across a broad range of inpatient services. Since 2016, the Honor Roll methodology has factored in both the specialty rankings and the Procedures & Conditions ratings (described in a separate methodology report issued by U.S. News). U.S. News added an additional Procedures & Conditions rating in 2023-2024 (Leukemia, Lymphoma & Myeloma), which has been incorporated into the Honor Roll methodology this year. Honor Roll, which appears in ***Appendix F***, was determined as follows.

1. In Rehabilitation, the No. 1-ranked hospital received 10 Honor Rolls points and lower-ranked hospitals progressively received one less point down to 1 point for all hospitals ranked 10-50. Hospitals that do not offer inpatient rehabilitation on site received points earned by a nearby affiliated hospital belonging to the same health system, if that affiliated hospital was ranked in Rehabilitation and earned fewer total points toward the Honor Roll from all other specialties combined.

2. In each of the other 11 data-driven specialty rankings, the No. 1-ranked hospital received 25 Honor Roll points and lower-ranked hospitals progressively received one less point down to six points for No. 20. All hospitals ranked 21–50 received 5 points. A hospital ranked No. 1 in all other 11 data-driven specialties would have received 25 x 11 = 275 points.

3. In each of the three expert opinion-based specialties, the No. 1-ranked hospital received 10 Honor Roll points, the No. 2 hospital received 9 points and lower-ranked hospitals progressively received one less point down to No. 10, which received 1 point. All hospitals from No. 11 to the last eligible hospital also received 1 point. A hospital ranked No. 1 in all three expert opinion-based specialties would have received 30 points.

4. In 17 of the 21 procedures and conditions for which U.S. News published ratings,[******] hospitals received 12 points for each rating of High Performing. Only six points were awarded for each High Performing rating in two procedures related to structural heart disease (Aortic Valve Surgery and TAVR) and another six points were awarded for each High Performing rating in two procedures related to gynecological oncology (ovarian and uterine cancer surgery), because these two pairs of procedures are different approaches to treating similar conditions. If a hospital were rated High Performing in all 21 procedures and conditions, it would receive 228 points.

5. The Honor Roll recognizes the 20 hospitals that earned the most points out of the possible total of 543 across the 15 specialties and 21 procedures & conditions. In 2023-2024, hospitals that earned 273 points or more are recognized.

Since it's often not advisable to travel long distances to receive hospital-based care, U.S. News ranks hospitals regionally in both states and major metro areas. Within a state or metro area, regional hospital rank is determined by a hospital's performance in the Best Hospitals Specialty Rankings and by its Procedures & Conditions ratings. Details of the scoring methodology for the Best Regional Hospitals listings by state and metro areas are available at http://health.usnews.com/health-care/best-hospitals/articles/faq-how-and-why-we-rank-and-rate-hospitals.

[******] Chronic obstructive pulmonary disease (COPD); congestive heart failure (CHF); heart attack; stroke; diabetes; kidney failure; pneumonia; hip replacement; knee replacement; back surgery; hip fracture; abdominal aortic aneurysm (AAA) repair; heart bypass surgery (CABG); aortic valve surgery; transcatheter aortic valve replacement (TAVR); colon cancer surgery; lung cancer surgery; prostate cancer surgery; ovarian cancer surgery; uterine cancer surgery and leukemia, lymphoma & myeloma.

VI. Changes to the Methodology for 2023-2024

A review of the changes to the methodology for this year of the Best Hospitals rankings is provided below. A brief description of changes made in past years can be found in Appendix C. For complete information on changes made in previous years, we recommend reviewing the project methodology reports for those years, which are available online at www.rti.org/besthospitals.

Methodological evolution is necessary because healthcare itself is constantly evolving. For example, the growing role of outpatient care served as an impetus for several of this year's changes. Stakeholder feedback led us to increase weight on objective quality measures, decrease weight on expert opinion, and add a transparency measure. Other input from clinical experts encouraged us to modify hospital eligibility criteria in several specialties and, in other specialties, revise case inclusion criteria. Changes to outcome measure definitions and risk adjustment, meanwhile, leveraged insights gained by the U.S. News team and scientific advances made by a federal agency.

- **Introducing outpatient outcomes in specialty rankings.** New "Prevention of outpatient procedural complications" outcome measures were added in this year's Orthopedics and Urology rankings, and similar outcome measures may be added in other specialties in future editions of Best Hospitals. These measures, calculated by U.S. News using novel software developed by 3M Health Information Systems, evaluate the ability of hospitals to reduce complications related to procedures performed in an outpatient setting. The new measures are important to patients because outpatient surgeries account for a growing share of surgical procedures in Orthopedics and Urology, as well as for a majority of all surgeries performed in the U.S.

- **Expanded inclusion of outpatient cases in volume measures in two other specialty rankings.** Volume measures and volume-based eligibility rules used in the Ear, Nose & Throat and Obstetrics & Gynecology rankings now include relevant outpatient procedural cases.

- **Increased weight on objective quality measures, and reduced weight on expert opinion.** The weight on outcome measures increased from 37.5% to 45% – and other objective measures increased from 35% to 40% – in each of 11 specialties. The weight on physician opinion was reduced from as much as 27.5% to either 12% or 15%, depending on the specialty.

- **Rehabilitation methodology revised**. Objective measures now account in aggregate for 70% of the methodology for Rehabilitation. Weights on objective measures increase for outcomes from 20% last year to 30% this year, for volume from 10% to 15%, for patient services and resources (from 12% to 15%), and for external recognitions (CARF accreditation and Model Systems participation) from 3% to 5%. The 5% weight placed on staff vaccination rates remains unchanged.

Additionally, the volume measure was redefined to encompass six rehabilitation impairment categories (RICs), up from three RICs previously, in order to represent a more comprehensive examination of the breadth of care provided by each hospital.

- **Transparency measures' weight standardized and expanded to a fourth specialty.** All transparency measures were given a standard weight of 3% in specialties that utilize these measures. A new transparency measure was added to the Pulmonology & Lung Surgery specialty rankings and Lung Cancer Surgery ratings, based on the Society of Thoracic Surgeons (STS) General Thoracic Surgery Database (GTSD) quality improvement program. That new measure, and three existing transparency measures in other specialties, each received a weight of 3%.

- **Risk adjustment.** Using criteria from the Elixhauser Comorbidity Software Refined for ICD-10-CM (version v2022.1), risk adjustment of all inpatient outcome measures in all specialties employed an expanded set of 38 comorbidities, compared to 29 comorbidities used in previous editions of Best Hospitals. Documentation describing v2022.1 of the Elixhauser software is publicly available at ahrq.gov.

- **Discharge to home outcome definition.** For the discharge to home outcome measure, discharges to an inpatient rehabilitation facility (IRF) were excluded from both the numerator and denominator. Previously these visits were treated as discharges to a location other than home. This change was made to reflect that a discharge to IRF suggests an intermediate outcome, which is less optimal than a discharge to home with full recovery but with better prospects for functional recovery than is implied by a discharge to SNF or long-term acute care.

- **Covid exclusions from outcome measures.** As in the prior year's rankings, certain visits were excluded from outcome measures to control for the disruptive and variable effects of the Covid-19 pandemic. However, these exclusion criteria were refined this year, such that a visit was excluded if it: a) occurred in March 2020; b) occurred in 2020 and the patient was diagnosed with Covid-19; or c) occurred between April 1, 2020, and December 31, 2020, and the hospital in which the visit occurred experienced a Covid-19 rate higher than the national mean or 15%, whichever was less, during the month in which the visit occurred. If the patient was diagnosed with Covid-19 in 2021 and onward, the visit is not excluded but is risk adjusted instead.

- **Nurse staffing.** Nurse staffing was calculated using data from the most recent single year available (i.e., the 2021 AHA survey database).

- **Winsorization of volume, nurse staffing and expert opinion.** Recent research demonstrates that hospital rankings determined by a composite of multiple measures are sensitive to the methods by which constituent measures are normalized.[40] Because volume, nurse staffing and expert opinion tend to have skewed distributions, with a small number of extremely high values, these measures were winsorized on the higher end of their distributions. That is, observed values

exceeding a certain threshold (e.g., greater than 25% for expert opinion) were replaced with the threshold score (e.g., 25%) prior to normalization of the measure. Similarly, the new outpatient outcome measures in Orthopedics and Urology were winsorized at their 99th percentile values.

- **Trauma center verification.** The project team took steps to independently verify that hospitals identified as trauma centers in the AHA Annual Survey Database did, in fact, have government-certified trauma centers on site.

- **Metastatic cancer cases excluded from Orthopedics.** To improve the homogeneity of the Orthopedics cohort, admissions involving a principal diagnosis of metastatic cancer were excluded.

- **HCAHPS adjustment for orthopedic and surgical hospitals.** In Orthopedics, to account for fundamental differences in the clinical characteristics of patients treated at specialty hospitals as compared to general acute-care hospitals, HCAHPS scores for orthopedic hospitals and surgical hospitals were algorithmically adjusted to be more comparable to scores observed across all general acute-care hospitals.

- **Specialty-specific eligibility criteria.** Eligibility criteria in Ear, Nose & Throat and Obstetrics & Gynecology were revised to consider total volume, including outpatient volume. Separately, cancer hospitals were excluded from five specialties (Diabetes & Endocrinology, Geriatrics, Orthopedics, Neurology & Neurosurgery, and Pulmonology & Lung Surgery) in which cancer care represents a relatively modest proportion of cases overall. This exclusion was introduced because the patient population previously included in each of those specialties was not comparable between cancer hospitals and hospitals that remain eligible in those specialties.

- **Cardiology, Heart & Vascular Surgery**. The specialty formerly known as Cardiology & Heart Surgery has been renamed Cardiology, Heart & Vascular Surgery, in recognition that vascular specialists take the lead on some cases that have consistently been included in the specialty's outcome measures. In certain contexts, U.S. News will use the shorthand Heart & Vascular to refer to Cardiology, Heart & Vascular Surgery.

- **Honor Roll**. Ordinal (numerical) rankings were not assigned to the Honor Roll this year.

VII. Future Enhancements

The Best Hospitals methodology is reexamined and refined each year. As always, RTI will closely monitor the potential of new data sources and measures. Below, we describe several methodological enhancements that are being considered.

- **Evaluate additional outcome measures for possible inclusion**. We will continue to evaluate new and alternative outcome measures that may provide unique information on performance of hospital in caring for patients.

- **Further refine the risk-adjustment of the outcome measures**. We will continue to evaluate additional risk-adjustment refinements that may provide more precise adjustment for patient mix factors, including social determinants of health.

- **Add objective data to expert opinion-based specialties.** We are examining opportunities to add structural data and outcome measures to the current expert opinion-based specialties.

- **Evaluate transparency measures for other specialties**. We will continue to evaluate new measures for transparency of outcomes, similar to the ACC, STS, and American Heart Association public transparency measures used in Cardiology, Heart & Vascular Surgery, the American Heart Association public transparency measure used in Neurology & Neurosurgery, and STS public transparency measure used in Pulmonology & Lung Surgery.

- **Review external data sources.** We will investigate additional and new sources of data that offer quality measures for all hospitals. Potential data sources include quality indicators from AHRQ, AHA, CMS and the Joint Commission.

VIII. Contact Information

We welcome suggestions and questions. Readers and users are encouraged to contact the Best Hospitals research team at the address listed below. This report, as well as all others from 2005 forward, can be viewed or downloaded from the RTI International website at www.rti.org/BestHospitals. Specific questions or comments about this report can be sent to BestHospitals@rti.org.

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Appendix A

Structural Variable Map

The following variables, used to construct structural elements of the 2023-2024 data-driven rankings, were taken from the 2021 Annual Survey of Hospitals Database published by the American Hospital Association, unless otherwise specified. Hospitals did not receive more than one point for any one service.

Key Technologies (8 points possible)

1 point awarded if...
DRADFHOS, DRADFSYS or DRADFVEN=1
FFDMHOS, FFDMSYS or FFDMVEN=1
IGRTHOS, IGRTSYS or IGRTVEN=1
MSCTHOS MSCTSYS, MSCTVEN, MSCTGHOS, MSCTGSYS or MSCTGVEN=1
PETCTHOS, PETCTSYS or PETCTVEN=1
ROBOHOS, ROBOSYS or ROBOVEN=1
SPECTHOS, SPECTSYS or SPECTVEN=1
SRADHOS, SRADSYS or SRADVEN=1

Cancer Advanced Technologies (8 points possible)

1 point awarded if...
FFDMHOS, FFDMSYS or FFDMVEN=1
IGRTHOS, IGRTSYS or IGRTVEN=1
IMRTHOS, IMRTSYS or IMRTVEN=1
ROBOHOS, ROBOSYS or ROBOVEN=1
PETCTHOS, PETCTSYS or PETCTVEN=1
BEAMHOS, BEAMSYS or BEAMVEN=1
SRADHOS, SRADSYS or SRADVEN=1
OTBONHOS, OTBONSYS or OTBONVEN=1

Cardiology, Heart & Vascular Surgery Advanced Technologies (6 points possible)

1 point awarded if...
MSCTHOS MSCTSYS, MSCTVEN, MSCTGHOS, MSCTGSYS or MSCTGVEN=1
PETCTHOS, PETCTSYS or PETCTVEN=1
ROBOHOS, ROBOSYS or ROBOVEN=1
SPECTHOS, SPECTSYS, SPECTVEN=1
TISUHOS, TISUSYS or TISUVEN=1
CMS Heart Transplant Center=1

Diabetes & Endocrinology Advanced Technologies (4 points possible)

1 point awarded if…
DRADFHOS, DRADFSYS or DRADFVEN=1
IGRTHOS, IGRTSYS or IGRTVEN=1
PETCTHOS, PETCTSYS or PETCTVEN=1
SRADHOS, SRADSYS or SRADVEN=1

Ear, Nose & Throat Advanced Technologies (1 point possible)

1 point awarded if…
SRADHOS, SRADSYS or SRADVEN=1

Gastroenterology & GI Surgery Advanced Technologies (7 points possible)

1 point awarded if…
DRADFHOS, DRADFSYS or DRADFVEN=1
ENDOAHOS, ENDOASYS or ENDOAVEN=1
ENDORHOS, ENDORSYS or ENDORVEN=1
ENDOUHOS, ENDOUSYS or ENDOUVEN=1
IGRTHOS, IGRTSYS or IGRTVEN=1
SRADHOS, SRADSYS or SRADVEN=1
CMS Liver Transplant Center=1

Obstetrics & Gynecology Advanced Technologies (5 points possible)

1 point awarded if…
FFDMHOS, FFDMSYS or FFDMVEN=1
IGRTHOS, IGRTSYS or IGRTVEN=1
PETCTHOS, PETCTSYS or PETCTVEN=1
ROBOHOS, ROBOSYS or ROBOVEN=1
SRADHOS, SRADSYS or SRADVEN=1

Neurology & Neurosurgery Advanced Technologies (5 points possible)

1 point awarded if…
DRADFHOS, DRADFSYS or DRADFVEN=1
IGRTHOS, IGRTSYS or IGRTVEN=1
PETCTHOS, PETCTSYS or PETCTVEN=1
SPECTHOS, SPECTSYS or SPECTVEN=1
SRADHOS, SRADSYS or SRADVEN=1

Orthopedics Advanced Technologies (2 points possible)

1 point awarded if…
CAOSHOS, CAOSSYS or CAOSVEN=1
TISUHOS, TISUSYS or TISUVEN=1

Pulmonology & Lung Surgery Advanced Technologies (6 points possible)

1 point awarded if…
DRADFHOS, DRADFSYS or DRADFVEN=1
IGRTHOS, IGRTSYS or IGRTVEN=1
MSCTHOS, MSCTSYS, MSCTVEN, MSCTGHOS, MSCTGSYS or MSCTGVEN=1
PETCTHOS, PETCTSYS or PETCTVEN=1
SRADHOS, SRADSYS or SRADVEN=1
CMS Lung Transplant Center=1

Rehabilitation Advanced Technologies (7 points possible)

1 point awarded if…
RASTHOS, RASTSYS, or RASTVEN=1
REDSHOS, REDSSYS, or REDSVEN=1
RPRSHOS, RPRSSYS, or RPRSVEN=1
RBOTHOS, RBOTSYS, or RBOTVEN=1
RSIMHOS, RSIMSYS, or RSIMVEN=1
CTSCNHOS, CTSCNSYS, or CTSCNVEN=1
PETCTHOS, PETCTSYS, or PETCTVEN=1

Urology Advanced Technologies (6 points possible)

1 point awarded if…
DRADFHOS, DRADFSYS or DRADFVEN=1
IGRTHOS, IGRTSYS or IGRTVEN=1
IMRTHOS, IMRTSYS or IMRTVEN=1
PETCTHOS, PETCTSYS or PETCTVEN=1
ROBOHOS, ROBOSYS or ROBOVEN=1
SRADHOS, SRADSYS or SRADVEN=1

Nurse Staffing

Index equals:
Calculation for hospitals with no onsite skilled nursing: Full-time Equivalent Registered Nurses (FTEN) divided by Adjusted Average Daily Census (ADJADC)[22]. In cases where FTEN is missing the value is imputed using a sample of hospitals with non-extreme ratios with the following data: FTEN (Full time equivalent registered nurses reported), FTERN (Full time equivalent registered nurses estimated), ADJADC (Adjusted Average Daily Census) BDTOT (total hospital beds set up and staffed). **Calculation for hospitals with onsite skilled nursing:** If a hospital has a nursing home type of long-term care unit (SUNITS=1) and reports registered nurse FTEs for this facility (FTERNLT>0), then calculate the ratio by dividing the Registered Nurses FTEs (FTEN) – the Registered Nurses FTEs assigned to the nursing facility (FTERNLT) by the modified Adjusted Average Daily Census (ADJADCH). Note that the ADJADCH is provided by the AHA directly to the project.

Trauma Center

"Yes" if…
TRAUML90=1 or 2 and TRAUMHOS=1

Cancer Patient Services (8 points possible)

1 point awarded if…
GNTCHOS, GNTCSYS or GNTCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
AIRBHOS, AIRBSYS or AIRBVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Cardiology, Heart & Vascular Surgery Patient Services (8 points possible)

1 point awarded if…
CHABHOS, CHABSYS or CHABVEN=1
CICHOS, CICSYS or CICVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1

[22] Based on the AHA documentation, the ADJADC is derived by first multiplying the number of inpatient days by the ratio of outpatient revenue per outpatient visit to inpatient revenue per inpatient day (to get the number of patient days attributable to outpatient services), then adding that to the number of inpatient days.

WMGTHOS, WMGTSYS or WMGTVEN=1

Diabetes & Endocrinology Patient Services (8 points possible)

1 point awarded if…
GNTCHOS, GNTCSYS or GNTCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
AIRBHOS, AIRBSYS or AIRBVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Ear, Nose & Throat Patient Services (8 points possible)

1 point awarded if…
GNTCHOS, GNTCSYS or GNTCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
AIRBHOS, AIRBSYSor AIRBVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Gastroenterology & GI Surgery Patient Services (8 points possible)

1 point awarded if…
GNTCHOS, GNTCSYS or GNTCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
AIRBHOS, AIRBSYS or AIRBVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Geriatric Care Patient Services (9 points possible)

1 point awarded if…
ALZHOS, ALZSYS or ALZVEN=1
ARTHCHOS, ARTHCSYS or ARTHCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYSor PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
PSYGRHOS, PSYGRSYS or PSYGRVEN=1
LINGHOS, LINGSYS or LINGVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Obstetrics & Gynecology Patient Services (9 points possible)

1 point awarded if…
FRTCHOS, FRTCSYS or FRTCVEN=1
CICHOS, CICSYS or CICVEN=1
GNTCHOS, GNTCSYS or GNTCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
AIRBHOS, AIRBSYS or AIRBVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Neurology & Neurosurgery Patient Services (9 points possible)

1 point awarded if…
ALZHOS, ALZSYS or ALZVEN=1
GNTCHOS, GNTCSYS or GNTCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
AIRBHOS, AIRBSYS or AIRBVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Orthopedics Patient Services (7 points possible)

1 point awarded if…
ARTHCHOS, ARTHCSYS or ARTHCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Pulmonology & Lung Surgery Patient Services (8 points possible)

1 point awarded if…
GNTCHOS, GNTCSYS or GNTCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
AIRBHOS, AIRBSYS or AIRBVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

Rehabilitation Patient Services (16 points possible)

1 point awarded if…
CMNGTHOS, CMNGTSYS, or CMNGTVEN=1
ENBHOS, ENBSYS, or ENBVEN=1
LINGHOS, LINGSYS, or LINGVEN=1
NEROHOS, NEROSYS, or NEROVEN=1
OCCHSHOS, OCCHSSYS, or OCCHSVEN=1
PAINHOS, PAINSYS, or PAINVEN=1
PATRPHOS, PATRPSYS, or PATRPVEN=1
RHBOPHOS, RHBOPSYS, or RHBOPVEN=1
PSYLSHOS, PSYLSSYS, or PSYLSVEN=1
SOCWKHOS, SOCWKSYS, or SOCWKVEN=1
WMGTHOS, WMGTSYS, or WMGTVEN=1
HLTRHOS, HLTRSYS, or HLTRVEN=1
HEMOHOS, HEMOSYS, or HEMOVEN=1
EMSSHOS, EMSSSYS, or EMSSVEN=1
PATEDHOS, PATEDSYS, or PATEDVEN=1
SUPPGHOS, SUPPGSYS, or SUPPGVEN=1

Urology Patient Services (9 points possible)

1 point awarded if…
FRTCHOS, FRTCSYS or FRTCVEN=1
GNTCHOS, GNTCSYS or GNTCVEN=1
HOSPCHOS, HOSPCSYS or HOSPCVEN=1
PAINHOS, PAINSYS or PAINVEN=1
PALHOS, PALSYS or PALVEN=1
PCAHOS, PCASYS or PCAVEN=1
LINGHOS, LINGSYS or LINGVEN=1
AIRBHOS, AIRBSYS or AIRBVEN=1
WMGTHOS, WMGTSYS or WMGTVEN=1

ICU Specialists

1 point awarded if…
if (FTEINT>0 or TPINT>0 or INTCAR>0 or FTEMSI>0 or FTECIC>0 or FTEOIC>0) then intens=1; if FTEINT>0 and FTEINT=sum(of FTENIC FTEPIC) then intens=0;

Appendix B

2023-2024 Diagnosis Related Group (DRG)

Groupings by Specialty

Cancer

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Allogeneic bone marrow transplant	014	Include all
		016	Include all
		017	Include all
S	Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator	023	Include procedures: 3E0Q005
M	Nervous system neoplasms	054	Include all
		055	Include all
M	Ear, nose, mouth & throat malignancy	146	Include all
		147	Include all
		148	Include all
M	Respiratory neoplasms	180	Include all
		181	Include all
		182	Include all
M	Digestive malignancy	374	Include all
		375	Include all
		376	Include all
M	Malignancy of hepatobiliary system or pancreas	435	Include all
		436	Include all
		437	Include all
S	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus	456	Include diagnoses: C41.2, C79.51, C79.52, C7B.03
		457	See MS-DRG 456
		458	See MS-DRG 456

Cancer (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Pathological fractures & musculoskelet & conn tiss malig	542	Exclude diagnoses: M30.1, M31.2, M31.30, M31.31, M48.40XA, M48.41XA, M48.42XA, M48.43XA, M48.44XA, M48.45XA, M48.46XA, M48.47XA, M48.48XA, M48.50XA, M48.51XA, M48.52XA, M48.53XA, M48.54XA, M48.55XA, M48.56XA, M48.57XA, M48.58XA, M80.00XA, M80.011A, M80.012A, M80.019A, M80.021A, M80.022A, M80.029A, M80.031A, M80.032A, M80.039A, M80.041A, M80.042A, M80.049A, M80.051A, M80.052A, M80.059A, M80.061A, M80.062A, M80.069A, M80.071A, M80.072A, M80.079A, M80.08XA, M80.80XA, M80.811A, M80.812A, M80.819A, M80.821A, M80.822A, M80.829A, M80.831A, M80.832A, M80.839A, M80.841A, M80.842A, M80.849A, M80.851A, M80.852A, M80.859A, M80.861A, M80.862A, M80.869A, M80.871A, M80.872A, M80.879A, M80.88XA, M84.30XA, M84.311A, M84.312A, M84.319A, M84.321A, M84.322A, M84.329A, M84.331A, M84.332A, M84.333A, M84.334A, M84.339A, M84.341A, M84.342A, M84.343A, M84.344A, M84.345A, M84.346A, M84.350A, M84.351A, M84.352A, M84.353A, M84.359A, M84.361A, M84.362A, M84.363A, M84.364A, M84.369A, M84.371A, M84.372A, M84.373A, M84.374A, M84.375A, M84.376A, M84.377A, M84.378A, M84.379A, M84.38XA, M84.40XA, M84.411A, M84.412A, M84.419A, M84.421A, M84.422A, M84.429A, M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.441A, M84.442A, M84.443A, M84.444A, M84.445A, M84.446A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.461A, M84.462A, M84.463A, M84.464A, M84.469A, M84.471A, M84.472A, M84.473A, M84.474A, M84.475A, M84.476A, M84.477A, M84.478A, M84.479A, M84.48XA, M84.50XA, M84.511A, M84.512A, M84.519A, M84.521A, M84.522A, M84.529A, M84.531A, M84.532A, M84.533A, M84.534A, M84.539A, M84.541A, M84.542A, M84.549A, M84.550A, M84.551A, M84.552A, M84.553A, M84.559A, M84.561A, M84.562A, M84.563A, M84.564A, M84.569A, M84.571A, M84.572A, M84.573A, M84.574A, M84.575A, M84.576A, M84.58XA, M84.60XA, M84.611A, M84.612A, M84.619A, M84.621A, M84.622A, M84.629A, M84.631A, M84.632A, M84.633A, M84.634A, M84.639A, M84.641A, M84.642A, M84.649A, M84.650A, M84.651A, M84.652A, M84.653A, M84.659A, M84.661A, M84.662A, M84.663A, M84.664A, M84.669A, M84.671A, M84.672A, M84.673A, M84.674A, M84.675A, M84.676A, M84.68XA, M84.750A, M84.751A, M84.752A, M84.753A, M84.754A, M84.755A, M84.756A, M84.757A, M84.758A, M84.759A
		543	See MS-DRG 542
		544	See MS-DRG 542
S	Mastectomy for malignancy	582	Include all
		583	Include all

Cancer (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Major skin disorders	595	Include diagnoses: C43.0, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, D03.0, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
		596	See MS-DRG 595
M	Malignant breast disorders	597	Include all
		598	Include all
		599	Include all
S	Kidney & ureter procedures for neoplasm	656	Include all
		657	Include all
		658	Include all
M	Kidney & urinary tract neoplasms	686	Include all
		687	Include all
		688	Include all
S	Other male reproductive system O.R. proc for malignancy	715	Include all
		716	Include all
M	Malignancy, male reproductive system	722	Include all
		723	Include all
		724	Include all
S	Uterine & adnexa proc for ovarian or adnexal malignancy	736	Include all
		737	Include all
		738	Include all
S	Uterine,adnexa proc for non-ovarian/adnexal malig	739	Include all
		740	Include all
		741	Include all
M	Malignancy, female reproductive system	754	Include all
		755	Include all
		756	Include all
M	Major hematol/immun diag exc sickle cell crisis & coagul	808	Include diagnoses: T86.00, T86.01, T86.02, T86.03, T86.09
		809	See MS-DRG 808
		810	See MS-DRG 808
S	Lymphoma & leukemia w major O.R. procedure	820	Include all
		821	Include all
		822	Include all
S	Lymphoma & non-acute leukemia w other O.R. proc	823	Include all
		824	Include all
		825	Include all

Cancer (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Myeloprolif disord or poorly diff neopl w maj O.R. proc	826	Exclude diagnoses: Z85.00, Z85.01, Z85.020, Z85.028, Z85.030, Z85.038, Z85.040, Z85.048, Z85.05, Z85.060, Z85.068, Z85.07, Z85.09, Z85.110, Z85.118, Z85.12, Z85.20, Z85.21, Z85.22, Z85.230, Z85.238, Z85.29, Z85.3, Z85.40, Z85.41, Z85.42, Z85.43, Z85.44, Z85.45, Z85.46, Z85.47, Z85.48, Z85.49, Z85.50, Z85.51, Z85.520, Z85.528, Z85.53, Z85.54, Z85.59, Z85.6, Z85.71, Z85.72, Z85.79, Z85.810, Z85.818, Z85.819, Z85.820, Z85.821, Z85.828, Z85.830, Z85.831, Z85.840, Z85.841, Z85.848, Z85.850, Z85.858, Z85.89, Z85.9, Z87.410
		827	See MS-DRG 826
		828	See MS-DRG 826
S	Myeloprolif disord or poorly diff neopl w other O.R. proc	829	See MS-DRG 826
		830	See MS-DRG 826
M	Acute leukemia w/o major O.R. procedure	834	Include all
		835	Include all
		836	Include all
M	Chemo w acute leukemia as sdx or w high dose chemo agent	837	Include all
		838	Include all
		839	Include all
M	Lymphoma & non-acute leukemia	840	Include all
		841	Include all
		842	Include all
M	Other myeloprolif dis or poorly diff neopl diag	843	See MS-DRG 826
		844	See MS-DRG 826
		845	See MS-DRG 826
M	Chemotherapy w/o acute leukemia as secondary diagnosis	846	Include all
		847	Include all
		848	Include all

Cardiology, Heart & Vascular Surgery*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Heart transplant or implant of heart assist system	001	Include all
		002	Include all
S	Major chest procedures	163	Include procedures: 025N0ZZ, 025N3ZZ, 025N4ZZ, 025P0ZZ, 025P3ZZ, 025P4ZZ, 025Q0ZZ, 025Q3ZZ, 025Q4ZZ, 025R0ZZ, 025R3ZZ, 025R4ZZ, 025S0ZZ, 025S3ZZ, 025S4ZZ, 025T0ZZ, 025T3ZZ, 025T4ZZ, 025V0ZZ, 025V3ZZ, 025V4ZZ, 025W0ZZ, 025W3ZZ, 025W4ZZ, 025X0ZZ, 025X3ZZ, 025X4ZZ, 02BN0ZX, 02BN0ZZ, 02BN3ZX, 02BN3ZZ, 02BN4ZX, 02BN4ZZ, 02BP0ZZ, 02BP3ZZ, 02BP4ZZ, 02BQ0ZZ, 02BQ3ZZ, 02BQ4ZZ, 02BR0ZZ, 02BR3ZZ, 02BR4ZZ, 02BS0ZZ, 02BS3ZZ, 02BS4ZZ, 02BT0ZZ, 02BT3ZZ, 02BT4ZZ, 02BV0ZZ, 02BV3ZZ, 02BV4ZZ, 02BW3ZZ, 02BX3ZZ, 02CN0ZZ, 02CN3ZZ, 02CN4ZZ, 02CP0ZZ, 02CP3ZZ, 02CP4ZZ, 02CQ0ZZ, 02CQ3ZZ, 02CQ4ZZ, 02CR0ZZ, 02CR3ZZ, 02CR4ZZ, 02CS0ZZ, 02CS3ZZ, 02CS4ZZ, 02CT0ZZ, 02CT3ZZ, 02CT4ZZ, 02CV0ZZ, 02CV3ZZ, 02CV4ZZ, 02HN00Z, 02HN02Z, 02HN30Z, 02HN40Z, 02HN42Z, 02NN0ZZ, 02NN3ZZ, 02NN4ZZ, 02QA0ZZ, 02RP07Z, 02RP08Z, 02RP0JZ, 02RP0KZ, 02RP47Z, 02RP48Z, 02RP4JZ, 02RP4KZ, 02RQ07Z, 02RQ08Z, 02RQ0JZ, 02RQ0KZ, 02RQ47Z, 02RQ48Z, 02RQ4JZ, 02RQ4KZ, 02RR07Z, 02RR08Z, 02RR0JZ, 02RR0KZ, 02RR47Z, 02RR48Z, 02RR4JZ, 02RR4KZ, 02RS07Z, 02RS08Z, 02RS0JZ, 02RS0KZ, 02RS47Z, 02RS48Z, 02RS4JZ, 02RS4KZ, 02RT07Z, 02RT08Z, 02RT0JZ, 02RT0KZ, 02RT47Z, 02RT48Z, 02RT4JZ, 02RT4KZ, 02RV07Z, 02RV08Z, 02RV0JZ, 02RV0KZ, 02RV47Z, 02RV48Z, 02RV4JZ, 02RV4KZ, 02RW07Z, 02RW08Z, 02RW0JZ, 02RW0KZ, 02RW47Z, 02RW48Z, 02RW4JZ, 02RW4KZ, 02RX07Z, 02RX08Z, 02RX0JZ, 02RX0KZ, 02RX47Z, 02RX48Z, 02RX4JZ, 02RX4KZ, 02TN0ZZ, 02TN3ZZ, 02TN4ZZ, 03500ZZ, 03503ZZ, 03504ZZ, 03510ZZ, 03513ZZ, 03514ZZ, 03520ZZ, 03523ZZ, 03524ZZ, 03530ZZ, 03533ZZ, 03534ZZ, 03540ZZ, 03543ZZ, 03544ZZ, 03B00ZZ, 03B03ZZ, 03B04ZZ, 03B10ZZ, 03B13ZZ, 03B14ZZ, 03B20ZZ, 03B23ZZ, 03B24ZZ, 03B30ZZ, 03B33ZZ, 03B34ZZ, 03B40ZZ, 03B43ZZ, 03B44ZZ, 03C00Z6, 03C00ZZ, 03C03Z6, 03C03ZZ, 03C04Z6, 03C04ZZ, 03C10Z6, 03C10ZZ, 03C13Z6, 03C13ZZ, 03C14Z6, 03C14ZZ, 03C20Z6, 03C20ZZ, 03C23Z6, 03C23ZZ, 03C24Z6, 03C24ZZ, 03C30Z6, 03C30ZZ, 03C33Z6, 03C33ZZ, 03C34Z6, 03C34ZZ, 03C40Z6, 03C40ZZ, 03C43Z6, 03C43ZZ, 03C44Z6, 03C44ZZ, 03L20CZ, 03L20DZ, 03L20ZZ, 03L23CZ, 03L23DZ, 03L23ZZ, 03L24CZ, 03L24DZ, 03L24ZZ, 03L30CZ, 03L30DZ, 03L30ZZ, 03L33CZ, 03L33DZ, 03L33ZZ, 03L34CZ, 03L34DZ, 03L34ZZ, 03L40CZ, 03L40DZ, 03L40ZZ, 03L43CZ, 03L43DZ, 03L43ZZ, 03L44CZ, 03L44DZ, 03L44ZZ, 03R007Z, 03R00JZ, 03R00KZ, 03R047Z, 03R04JZ, 03R04KZ, 03R107Z, 03R10JZ, 03R10KZ, 03R147Z, 03R14JZ, 03R14KZ, 03R207Z, 03R20JZ, 03R20KZ, 03R247Z, 03R24JZ, 03R24KZ, 03R307Z, 03R30JZ, 03R30KZ, 03R347Z, 03R34JZ, 03R34KZ, 03R407Z, 03R40JZ, 03R40KZ, 03R447Z, 03R44JZ, 03R44KZ, 05500ZZ, 05503ZZ, 05504ZZ, 05510ZZ, 05513ZZ,

*Exclude principal diagnosis: T8021 (central-line-associated bloodstream infections)

Cardiology, Heart & Vascular Surgery (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Major chest procedures (cont.)	163 (cont.)	05514ZZ, 05530ZZ, 05533ZZ, 05534ZZ, 05540ZZ, 05543ZZ, 05544ZZ, 05550ZZ, 05553ZZ, 05554ZZ, 05560ZZ, 05563ZZ, 05564ZZ, 05B00ZZ, 05B03ZZ, 05B04ZZ, 05B10ZZ, 05B13ZZ, 05B14ZZ, 05B30ZZ, 05B33ZZ, 05B34ZZ, 05B40ZZ, 05B43ZZ, 05B44ZZ, 05B50ZZ, 05B53ZZ, 05B54ZZ, 05B60ZZ, 05B63ZZ, 05B64ZZ, 05C00ZZ, 05C04ZZ, 05C10ZZ, 05C14ZZ, 05C30ZZ, 05C34ZZ, 05C40ZZ, 05C44ZZ, 05C50ZZ, 05C54ZZ, 05C60ZZ, 05C64ZZ, 05L30CZ, 05L30DZ, 05L30ZZ, 05L33CZ, 05L33DZ, 05L33ZZ, 05L34CZ, 05L34DZ, 05L34ZZ, 05L40CZ, 05L40DZ, 05L40ZZ, 05L43CZ, 05L43DZ, 05L43ZZ, 05L44CZ, 05L44DZ, 05L44ZZ, 05L50CZ, 05L50DZ, 05L50ZZ, 05L53CZ, 05L53DZ, 05L53ZZ, 05L54CZ, 05L54DZ, 05L54ZZ, 05L60CZ, 05L60DZ, 05L60ZZ, 05L63CZ, 05L63DZ, 05L63ZZ, 05L64CZ, 05L64DZ, 05L64ZZ, 05R007Z, 05R00JZ, 05R00KZ, 05R047Z, 05R04JZ, 05R04KZ, 05R107Z, 05R10JZ, 05R10KZ, 05R147Z, 05R14JZ, 05R14KZ, 05R307Z, 05R30JZ, 05R30KZ, 05R347Z, 05R34JZ, 05R34KZ, 05R407Z, 05R40JZ, 05R40KZ, 05R447Z, 05R44JZ, 05R44KZ, 05R507Z, 05R50JZ, 05R50KZ, 05R547Z, 05R54JZ, 05R54KZ, 05R607Z, 05R60JZ, 05R60KZ, 05R647Z, 05R64JZ, 05R64KZ, 0W9D00Z, 0W9D0ZX, 0W9D0ZZ, 0WCD0ZZ, 0WCD3ZZ, 0WCD4ZZ, 0WHD03Z, 0WHD0YZ, 0WHD33Z, 0WHD3YZ, 0WHD43Z, 0WHD4YZ, 0WPD00Z, 0WPD01Z, 0WPD03Z, 0WPD0YZ, 0WPD30Z, 0WPD31Z, 0WPD33Z, 0WPD3YZ, 0WPD40Z, 0WPD41Z, 0WPD43Z, 0WPD4YZ, 0WWD00Z, 0WWD01Z, 0WWD03Z, 0WWD0YZ, 0WWD30Z, 0WWD31Z, 0WWD33Z, 0WWD3YZ, 0WWD40Z, 0WWD41Z, 0WWD43Z, 0WWD4YZ
		164	See MS-DRG: 163
		165	See MS-DRG: 163
S	Other heart assist system implant	215	Include all
S	Cardiac valve & oth maj cardiothoracic proc w card cath	216	Include all
		217	Include all
		218	Include all
S	Cardiac valve & oth maj cardiothoracic proc w/o card cath	219	Include all
		220	Include all
		221	Include all
S	Cardiac defib implant w cardiac cath w AMI/HF/shock	222	Include all
		223	Include all
S	Cardiac defib implant w cardiac cath w/o AMI/HF/shock	224	Include all
		225	Include all
S	Cardiac defibrillator implant w/o cardiac cath	226	Include all
		227	Include all
S	Other cardiothoracic procedures	228	Include all
		229	Include all
		230	Include all
S	Coronary bypass w PTCA	231	Include all
		232	Include all
S	Coronary bypass w cardiac cath	233	Include all
		234	Include all
S	Coronary bypass w/o cardiac cath	235	Include all
		236	Include all

*Exclude principal diagnosis: T8021 (central-line-associated bloodstream infections)

Cardiology, Heart & Vascular Surgery (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Permanent cardiac pacemaker implant	242	Include all
		243	Include all
		244	Include all
S	AICD generator procedures	245	Include all
S	Perc cardiovasc proc w drug-eluting stent	246	Include all
		247	Include all
S	Perc cardiovasc proc w non-drug-eluting stent	248	Include all
		249	Include all
S	Perc cardiovasc proc w/o coronary artery stent	250	Include all
		251	Include all
S	Other vascular procedures	252	Include all
		253	Include all
		254	Include all
S	Cardiac pacemaker revision except device replacement	260	Include all
		261	Include all
		262	Include all
S	ACID lead procedures	265	Include all
S	Endovascular cardiac valve replacement	266	Include all
		267	Include all
S	Aortic and heart assist procedures except pulsation balloon	268	Include all
		269	Include all
S	Other major cardiovascular procedures	270	Include all
		271	Include all
		272	Include all
S	Percutaneous intracardiac procedures	273	Include all
		274	Include all
M	Acute myocardial infarction, discharged alive	280	Include all
		281	Include all
		282	Include all
M	Acute myocardial infarction, expired	283	Include all
		284	Include all
		285	Include all
M	Circulatory disorders except AMI, w card cath	286	Include all
		287	Include all
M	Acute & subacute endocarditis	288	Include all
		289	Include all
		290	Include all
M	Heart failure & shock	291	Include all
		292	Include all
		293	Include all
M	Cardiac congenital & valvular disorders	306	Include all
		308	Include all
		309	Include all
M	Other circulatory system diagnoses	314	Include all
		315	Include all
		316	Include all
S	Other endovascular cardiac valve procedures	319	Include all
		320	Include all

*Exclude principal diagnosis: T8021 (central-line-associated bloodstream infections)

Diabetes & Endocrinology

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Adrenal & pituitary procedures	614	Include all
		615	Include all
S	O.R. procedures for obesity	619	Include all
		620	Include all
		621	Include all
S	Skin grafts & wound debrid for endoc, nutrit & metab dis	622	Include all
		623	Include all
		624	Include all
S	Thyroid, parathyroid & thyroglossal procedures	625	Include all
		626	Include all
		627	Include all
S	Other endocrine, nutrit & metab O.R. proc	628	Include all
		629	Include all
		630	Include all
M	Diabetes	637	Include all
		638	Include all
		639	Include all
M	Misc disorders of nutrition, metabolism, fluids/electrolyes	640	Exclude diagnosis: P92.6
M	Endocrine disorders	643	Include all
		644	Include all

Ear, Nose & Throat

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Tracheostomy for face,mouth & neck diagnoses	011	Include all
		012	Include all
		013	Include all
S	Major head & neck procedures	129	Include all
		130	Include all
S	Cranial/Facial Procedures	131	Include all
		132	Include all
S	Other ear, nose, mouth & throat O.R. procedures	133	Include all
		134	Include all
S	Salivary gland procedures	139	Include all
M	Ear, nose, mouth & throat malignancy	146	Include all
		147	Include all
		148	Include all
M	Otitis media & URI	152	Include all
M	Other ear, nose, mouth and throat diagnosis	154	Include all
		155	Include all
		156	Include all

Gastroenterology & GI Surgery

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Stomach, esophageal & duodenal proc	326	Include all
		327	Include all
		328	Include all
S	Major small & large bowel procedures	329	Include all
		330	Include all
		331	Include all
S	Rectal resection	332	Include all
		333	Include all
		334	Include all
S	Peritoneal adhesiolysis	335	Include all
		336	Include all
		337	Include all
S	Minor small & large bowel procedures	344	Include procedures: 0D580ZZ, 0D583ZZ, 0D584ZZ, 0D587ZZ, 0D588ZZ, 0D5A0ZZ, 0D5A3ZZ, 0D5A4ZZ, 0D5A7ZZ, 0D5A8ZZ, 0D5B0ZZ, 0D5B3ZZ, 0D5B4ZZ, 0D5B7ZZ, 0D5B8ZZ, 0D5C0ZZ, 0D5C3ZZ, 0D5C4ZZ, 0D5C7ZZ, 0D5C8ZZ, 0D5E0ZZ, 0D5E3ZZ, 0D5E7ZZ, 0D5F0ZZ, 0D5F3ZZ, 0D5F7ZZ, 0D5G0ZZ, 0D5G3ZZ, 0D5G7ZZ, 0D5H0ZZ, 0D5H3ZZ, 0D5H7ZZ, 0D5K0ZZ, 0D5K3ZZ, 0D5K7ZZ, 0D5L0ZZ, 0D5L3ZZ, 0D5L7ZZ, 0D5M0ZZ, 0D5M3ZZ, 0D5M7ZZ, 0D5N0ZZ, 0D5N3ZZ, 0D5N7ZZ, 0D9800Z, 0D980ZX, 0D980ZZ, 0D9840Z, 0D984ZZ, 0D9870Z, 0D987ZZ, 0D9880Z, 0D988ZZ, 0D990ZX, 0D9A00Z, 0D9A0ZX, 0D9A0ZZ, 0D9A40Z, 0D9A4ZZ, 0D9A7ZZ, 0D9A8ZZ, 0D9B00Z, 0D9B0ZX, 0D9B0ZZ, 0D9B40Z, 0D9B4ZZ, 0D9B7ZZ, 0D9B8ZZ, 0D9C00Z, 0D9C0ZX, 0D9C0ZZ, 0D9C40Z, 0D9C4ZZ, 0D9C70Z, 0D9C7ZZ, 0D9C80Z, 0D9C8ZZ, 0D9E00Z, 0D9E0ZX, 0D9E0ZZ, 0D9E40Z, 0D9E4ZZ, 0D9E7ZZ, 0D9E8ZZ, 0D9F00Z, 0D9F0ZX, 0D9F0ZZ, 0D9F40Z, 0D9F4ZZ, 0D9F7ZZ, 0D9F8ZZ, 0D9G00Z, 0D9G0ZX, 0D9G0ZZ, 0D9G40Z, 0D9G4ZZ, 0D9G7ZZ, 0D9G8ZZ, 0D9H00Z, 0D9H0ZX, 0D9H0ZZ, 0D9H40Z, 0D9H4ZZ, 0D9H7ZZ, 0D9H8ZZ, 0D9K00Z, 0D9K0ZX, 0D9K0ZZ, 0D9K40Z, 0D9K4ZZ, 0D9K7ZZ, 0D9K8ZZ, 0D9L00Z, 0D9L0ZX, 0D9L0ZZ, 0D9L40Z, 0D9L4ZZ, 0D9L7ZZ, 0D9L8ZZ, 0D9M00Z, 0D9M0ZX, 0D9M0ZZ, 0D9M40Z, 0D9M4ZZ, 0D9M7ZZ, 0D9M8ZZ, 0D9N00Z, 0D9N0ZX, 0D9N0ZZ, 0D9N40Z, 0D9N4ZZ, 0D9N7ZZ, 0D9N8ZZ, 0D9P0ZX, 0D9P0ZZ, 0D9P4ZZ, 0D9P7ZZ, 0D9P8ZZ, 0DB80ZX, 0DB90ZX, 0DBA0ZX, 0DBB0ZX, 0DBC0ZX, 0DBE0ZX, 0DBF0ZX, 0DBG0ZX, 0DBH0ZX, 0DBK0ZX, 0DBL0ZX, 0DBM0ZX, 0DBN0ZX, 0DBP0ZX, 0DC80ZZ, 0DC83ZZ, 0DC84ZZ, 0DCA0ZZ, 0DCA3ZZ, 0DCA4ZZ, 0DCB0ZZ, 0DCB3ZZ, 0DCB4ZZ, 0DCC0ZZ, 0DCC3ZZ, 0DCC4ZZ, 0DCE0ZZ, 0DCE3ZZ, 0DCE4ZZ, 0DCF0ZZ, 0DCF3ZZ, 0DCF4ZZ, 0DCG0ZZ, 0DCG3ZZ, 0DCG4ZZ, 0DCH0ZZ, 0DCH3ZZ, 0DCH4ZZ, 0DCK0ZZ, 0DCK3ZZ, 0DCK4ZZ, 0DCL0ZZ, 0DCL3ZZ, 0DCL4ZZ, 0DCM0ZZ, 0DCM3ZZ, 0DCM4ZZ, 0DCN0ZZ, 0DCN3ZZ, 0DCN4ZZ, 0DCP0ZZ, 0DCP3ZZ, 0DCP4ZZ, 0DH802Z, 0DH803Z, 0DH832Z, 0DH833Z, 0DH842Z, 0DH843Z, 0DHA02Z, 0DHA03Z, 0DHA32Z, 0DHA33Z, 0DHA42Z, 0DHA43Z, 0DHB02Z, 0DHB03Z, 0DHB32Z, 0DHB33Z, 0DHB42Z, 0DHB43Z,

Gastroenterology & GI Surgery (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Minor small & large bowel procedures (cont.)	344 (cont.)	0DP000Z, 0DP002Z, 0DP003Z, 0DP007Z, 0DP00CZ, 0DP00DZ, 0DP00JZ, 0DP00KZ, 0DP00UZ, 0DP00YZ, 0DP030Z, 0DP032Z, 0DP033Z, 0DP037Z, 0DP03CZ, 0DP03DZ, 0DP03JZ, 0DP03KZ, 0DP03UZ, 0DP03YZ, 0DP040Z, 0DP042Z, 0DP043Z, 0DP047Z, 0DP04CZ, 0DP04DZ, 0DP04JZ, 0DP04KZ, 0DP04UZ, 0DP077Z, 0DP07CZ, 0DP07JZ, 0DP07KZ, 0DP087Z, 0DP08CZ, 0DP08JZ, 0DP08KZ, 0DPD00Z, 0DPD02Z, 0DPD03Z, 0DPD07Z, 0DPD0CZ, 0DPD0DZ, 0DPD0JZ, 0DPD0KZ, 0DPD0UZ, 0DPD0YZ, 0DPD30Z, 0DPD32Z, 0DPD33Z, 0DPD37Z, 0DPD3CZ, 0DPD3DZ, 0DPD3JZ, 0DPD3KZ, 0DPD3UZ, 0DPD40Z, 0DPD42Z, 0DPD43Z, 0DPD47Z, 0DPD4CZ, 0DPD4DZ, 0DPD4JZ, 0DPD4KZ, 0DPD4UZ, 0DPD77Z, 0DPD7CZ, 0DPD7JZ, 0DPD7KZ, 0DPD87Z, 0DPD8CZ, 0DPD8JZ, 0DPD8KZ, 0DPP01Z, 0DPP31Z, 0DPP41Z, 0DS90ZZ, 0DS94ZZ, 0DS97ZZ, 0DS98ZZ, 0DSA0ZZ, 0DSA4ZZ, 0DSA7ZZ, 0DSA8ZZ, 0DSK0ZZ, 0DSK4ZZ, 0DSK7ZZ, 0DSK8ZZ, 0DSL0ZZ, 0DSL4ZZ, 0DSL7ZZ, 0DSL8ZZ, 0DSM0ZZ, 0DSM4ZZ, 0DSM7ZZ, 0DSM8ZZ, 0DSN0ZZ, 0DSN4ZZ, 0DSN7ZZ, 0DSN8ZZ, 0DW000Z, 0DW002Z, 0DW003Z, 0DW007Z, 0DW00CZ, 0DW00DZ, 0DW00JZ, 0DW00KZ, 0DW00UZ, 0DW00YZ, 0DW030Z, 0DW032Z, 0DW033Z, 0DW037Z, 0DW03CZ, 0DW03DZ, 0DW03JZ, 0DW03KZ, 0DW03UZ, 0DW040Z, 0DW042Z, 0DW043Z, 0DW047Z, 0DW04CZ, 0DW04DZ, 0DW04JZ, 0DW04KZ, 0DW04YZ, 0DW070Z, 0DW072Z, 0DW073Z, 0DW077Z, 0DW07CZ, 0DW07DZ, 0DW07JZ, 0DW07KZ, 0DW07UZ, 0DW080Z, 0DW082Z, 0DW083Z, 0DW087Z, 0DW08CZ, 0DW08DZ, 0DW08JZ, 0DW08KZ, 0DW08UZ, 0DWD00Z, 0DWD02Z, 0DWD03Z, 0DWD07Z, 0DWD0CZ, 0DWD0DZ, 0DWD0JZ, 0DWD0KZ, 0DWD0UZ, 0DWD0YZ, 0DWD30Z, 0DWD32Z, 0DWD33Z, 0DWD37Z, 0DWD3CZ, 0DWD3DZ, 0DWD3JZ, 0DWD3KZ, 0DWD3UZ, 0DWD40Z, 0DWD42Z, 0DWD43Z, 0DWD47Z, 0DWD4CZ, 0DWD4DZ, 0DWD4JZ, 0DWD4KZ, 0DWD4UZ, 0DWD4YZ, 0DWD70Z, 0DWD72Z, 0DWD73Z, 0DWD77Z, 0DWD7CZ, 0DWD7DZ, 0DWD7JZ, 0DWD7KZ, 0DWD7UZ, 0DWD80Z, 0DWD82Z, 0DWD83Z, 0DWD87Z, 0DWD8CZ, 0DWD8DZ, 0DWD8JZ, 0DWD8KZ, 0DWD8UZ, 0TQB0ZZ, 0TQB3ZZ, 0TQB4ZZ, 0TQB7ZZ, 0TQB8ZZ, 0WQFXZ2
		345	See MS-DRG 344
		346	See MS-DRG 344
S	Other digestive system O.R. procedures	356	Include all
		357	Include all
		358	Include all
M	Major esophageal disorders	368	Include all
		369	Include all
		370	Include all
M	Major gastrointestinal disorders & peritoneal infections	371	Include all
		372	Include all
		373	Include all

Gastroenterology & GI Surgery (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Digestive malignancy	374	Include all
		375	Include all
		376	Include all
M	G.I. hemorrhage	377	Include all
		378	Include all
		379	Include all
M	Complicated peptic ulcer	380	Include all
		381	Include all
		382	Include all
M	Uncomplicated peptic ulcer	383	Include all
M	Inflammatory bowel disease	385	Include all
		386	Include all
		387	Include all
M	G.I. obstruction	388	Include all
		389	Include all
M	Esophagitis, gastroent & misc digest disorders	391	Include all
M	Other digestive system diagnoses	393	Include all
		394	Include all
S	Pancreas, liver & shunt procedures	405	Include all
		406	Include all
		407	Include all
S	Biliary tract proc except only cholecyst w or w/o c.d.e.	408	Include all
		409	Include all
		410	Include all
S	Cholecystectomy w c.d.e.	411	Include all
		412	Include all
		413	Include all
S	Cholecystectomy except by laparoscope w/o c.d.e.	414	Include all
		415	Include all
S	Laparoscopic cholecystectomy w/o c.d.e.	417	Include all
		418	Include all
S	Hepatobiliary diagnostic procedures	420	Include all
		421	Include all
		422	Include all
S	Other hepatobiliary or pancreas O.R. procedures	423	Include all
		424	Include all
		425	Include all
M	Cirrhosis & alcoholic hepatitis	432	Include all
		433	Include all
		434	Include all
M	Malignancy of hepatobiliary system or pancreas	435	Include all
		436	Include all
		437	Include all
M	Disorders of pancreas except malignancy	438	Include all
		439	Include all
		440	Include all
M	Disorders of liver except malig,cirr,alc hepa	441	Exclude diagnosis: R94.5
		442	See MS-DRG 441

Geriatrics*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Heart transplant or implant of heart assist system	001	Include all
		002	Include all
S	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	003	Include all
S	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	004	Include all
S	Liver transplant	005	Include all
		006	Include all
S	Lung transplant	007	Include all
S	Simultaneous pancreas/kidney transplant	008	Include all
S	Pancreas transplant	010	Include all
S	Tracheostomy for face,mouth & neck diagnoses	011	Include all
		012	Include all
		013	Include all
S	Allogeneic bone marrow transplant	014	Include all
		016	Include all
		017	Include all
S	Intracranial vascular procedures w PDX hemorrhage	020	Include all
		021	Include all
		022	Include all
S	Cranio w major dev impl/acute complex CNS PDX	023	Include all
		024	Include all
S	Craniotomy & endovascular intracranial procedures	025	Include all
		026	Include all
		027	Include all
S	Spinal procedures	028	Include all
		029	Include all
		030	Include all
S	Ventricular shunt procedures	031	Include all
		032	Include all
		033	Include all
S	Carotid artery stent procedure	034	Include all
		035	Include all
		036	Include all
S	Extracranial procedures	037	Include all
		038	Include all
		039	Include all
S	Periph & cranial nerve & other nerv syst proc	040	Include all
		041	Include all
		042	Include all
M	Spinal disorders & injuries	052	Include all
		053	Include all
M	Nervous system neoplasms	054	Include all
		055	Include all
M	Degenerative nervous system disorders	056	Include all
		057	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Multiple sclerosis & cerebellar ataxia	058	Include all
		059	Include all
		060	Include all
M	Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent	061	Include all
		062	Include all
		063	Include all
M	Intracranial hemorrhage or cerebral infarction	064	Include all
		065	Include all
		066	Include all
M	Nonspecific cva & precerebral occlusion w/o infarct	067	Include all
		068	Include all
M	Transient ischemia	069	Include all
M	Nonspecific cerebrovascular disorders	070	Include all
		071	Include all
		072	Include all
M	Cranial & peripheral nerve disorders	073	Include all
		074	Include all
M	Viral meningitis	075	Include all
		076	Include all
M	Hypertensive encephalopathy	077	Include all
		078	Include all
		079	Include all
M	Nontraumatic stupor & coma	080	Include all
		081	Include all
M	Traumatic stupor & coma, coma >1 hr	082	Include all
		083	Include all
		084	Include all
M	Traumatic stupor & coma, coma <1 hr	085	Include all
		086	Include all
		087	Include all
M	Concussion	088	Include all
		089	Include all
		090	Include all
M	Other disorders of nervous system	091	Include all
		092	Include all
		093	Include all
M	Bacterial & tuberculous infections of nervous system	094	Include all
		095	Include all
		096	Include all
M	Non-bacterial infect of nervous sys exc viral meningitis	097	Include all
		098	Include all
		099	Include all
M	Seizures	100	Include all
		101	Include all
M	Headaches	102	Include all
		103	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Orbital procedures	113	Include all
		114	Include all
S	Extraocular procedures except orbit	115	Include all
S	Intraocular procedures	116	Include all
		117	Include all
M	Acute major eye infections	121	Include all
		122	Include all
M	Neurological eye disorders	123	Include all
M	Other disorders of the eye	124	Include all
		125	Include all
S	Major head & neck procedures	129	Include all
		130	Include all
S	Cranial/facial procedures	131	Include all
		132	Include all
S	Other ear, nose, mouth & throat O.R. procedures	133	Include all
		134	Include all
S	Sinus & mastoid procedures	135	Include all
		136	Include all
S	Mouth procedures	137	Include all
		138	Include all
S	Salivary gland procedures	139	Include all
M	Ear, nose, mouth & throat malignancy	146	Include all
		147	Include all
		148	Include all
M	Dysequilibrium	149	Include all
M	Epistaxis	150	Include all
		151	Include all
M	Otitis media & URI	152	Include all
		153	Include all
M	Other Ear, Nose, Mouth, and Throat Diagnoses	154	Include all
		155	Include all
		156	Include all
M	Dental & Oral Diseases	157	Include all
		158	Include all
		159	Include all
S	Major chest procedures	163	Include all
		164	Include all
		165	Include all
S	Other resp system O.R. procedures	166	Include all
		167	Include all
		168	Include all
M	Pulmonary embolism	175	Include all
		176	Include all
M	Respiratory infections & inflammations	177	Include all
		178	Include all
		179	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Respiratory neoplasms	180	Include all
		181	Include all
		182	Include all
M	Major chest trauma	183	Include all
		184	Include all
		185	Include all
M	Pleural effusion	186	Include all
		187	Include all
		188	Include all
M	Pulmonary edema & respiratory failure	189	Include all
M	Chronic obstructive pulmonary disease	190	Include all
		191	Include all
		192	Include all
M	Simple pneumonia & pleurisy	193	Include all
		194	Include all
		195	Include all
M	Interstitial lung disease	196	Include all
		197	Include all
		198	Include all
M	Pneumothorax	199	Include all
		200	Include all
		201	Include all
M	Bronchitis & asthma	202	Include all
		203	Include all
M	Respiratory signs & symptoms	204	Include all
M	Other respiratory system diagnoses	205	Include all
		206	Include all
M	Respiratory system diagnosis w ventilator support	207	Include all
		208	Include all
S	Other heart assist system implant	215	Include all
S	Cardiac valve & oth maj cardiothoracic proc w card cath	216	Include all
		217	Include all
		218	Include all
S	Cardiac valve & oth maj cardiothoracic proc w/o card cath	219	Include all
		220	Include all
		221	Include all
S	Cardiac defib implant w cardiac cath w AMI/HF/shock	222	Include all
		223	Include all
S	Cardiac defib implant w cardiac cath w/o AMI/HF/shock	224	Include all
		225	Include all
S	Cardiac defibrillator implant w/o cardiac cath	226	Include all
		227	Include all
S	Other cardiothoracic procedures	228	Include all
		229	Include all
		230	Include all
S	Coronary bypass w PTCA	231	Include all
		232	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Coronary bypass w cardiac cath	233	Include all
		234	Include all
S	Coronary bypass w/o cardiac cath	235	Include all
		236	Include all
S	Amputation for circ sys disorders exc upper limb & toe	239	Include all
		240	Include all
		241	Include all
S	Permanent cardiac pacemaker implant	242	Include all
		243	Include all
		244	Include all
S	AICD generator procedures	245	Include all
S	Perc cardiovasc proc w drug-eluting stent	246	Include all
		247	Include all
		248	Include all
S	Perc cardiovasc proc w non-drug-eluting stent	249	Include all
		250	Include all
		251	Include all
S	Other vascular procedures	252	Include all
		253	Include all
		254	Include all
S	Upper limb & toe amputation for circ system disorders	255	Include all
		256	Include all
		257	Include all
S	Cardiac pacemaker device replacement	258	Include all
		259	Include all
S	Cardiac pacemaker revision except device replacement	260	Include all
		261	Include all
		262	Include all
S	Vein ligation & stripping	263	Include all
S	Other circulatory system O.R. procedures	264	Include all
S	AICD lead procedures	265	Include all
S	Endovascular Cardiac Valve Replacement	266	Include all
		267	Include all
S	Aortic and heart assist procedures except pulsation balloon	268	Include all
		269	Include all
S	Other major cardiovascular procedures	270	Include all
		271	Include all
		272	Include all
S	Percutaneous intracardiac procedures	273	Include all
		274	Include all
M	Acute myocardial infarction, discharged alive	280	Include all
		281	Include all
		282	Include all
M	Acute myocardial infarction, expired	283	Include all
		284	Include all
		285	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Circulatory disorders except AMI, w card cath	286	Include all
		287	Include all
M	Acute & subacute endocarditis	288	Include all
		289	Include all
		290	Include all
M	Heart failure & shock	291	Include all
		292	Include all
		293	Include all
M	Deep vein thrombophlebitis	294	Include all
		295	Include all
M	Cardiac arrest, unexplained	296	Include all
		297	Include all
		298	Include all
M	Peripheral vascular disorders	299	Include all
		300	Include all
		301	Include all
M	Atherosclerosis	302	Include all
		303	Include all
M	Hypertension	304	Include all
		305	Include all
M	Cardiac congenital & valvular disorders	306	Include all
		307	Include all
M	Cardiac arrhythmia & conduction disorders	308	Include all
		309	Include all
		310	Include all
M	Angina pectoris	311	Include all
M	Syncope & collapse	312	Include all
M	Chest pain	313	Include all
M	Other circulatory system diagnoses	314	Include all
		315	Include all
		316	Include all
S	Stomach, esophageal & duodenal proc	326	Include all
		327	Include all
		328	Include all
S	Major small & large bowel procedures	329	Include all
		330	Include all
		331	Include all
S	Rectal resection	332	Include all
		333	Include all
		334	Include all
S	Peritoneal adhesiolysis	335	Include all
		336	Include all
		337	Include all
S	Appendectomy w complicated principal diag	338	Include all
		339	Include all
		340	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Appendectomy w/o complicated principal diag	341	Include all
		342	Include all
		343	Include all
S	Minor small & large bowel procedures	344	Include all
		345	Include all
		346	Include all
S	Anal & stomal procedures	347	Include all
		348	Include all
		349	Include all
S	Inguinal & femoral hernia procedures	350	Include all
		351	Include all
		352	Include all
S	Hernia procedures except inguinal & femoral	353	Include all
		354	Include all
		355	Include all
S	Other digestive system O.R. procedures	356	Include all
		357	Include all
		358	Include all
M	Major esophageal disorders	368	Include all
		369	Include all
		370	Include all
M	Major gastrointestinal disorders & peritoneal infections	371	Include all
		372	Include all
		373	Include all
M	Digestive malignancy	374	Include all
		375	Include all
		376	Include all
M	G.I. hemorrhage	377	Include all
		378	Include all
		379	Include all
M	Complicated peptic ulcer	380	Include all
		381	Include all
		382	Include all
M	Uncomplicated peptic ulcer	383	Include all
		384	Include all
M	Inflammatory bowel disease	385	Include all
		386	Include all
		387	Include all
M	G.I. obstruction	388	Include all
		389	Include all
		390	Include all
M	Esophagitis, gastroent & misc digest disorders	391	Include all
		392	Include all
M	Other digestive system diagnoses	393	Include all
		394	Include all
		395	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Pancreas, liver & shunt procedures	405	Include all
		406	Include all
		407	Include all
S	Biliary tract proc except only cholecyst w or w/o c.d.e.	408	Include all
		409	Include all
		410	Include all
S	Cholecystectomy w c.d.e.	411	Include all
		412	Include all
		413	Include all
S	Cholecystectomy except by laparoscope w/o c.d.e.	414	Include all
		415	Include all
		416	Include all
S	Laparoscopic cholecystectomy w/o c.d.e.	417	Include all
		418	Include all
		419	Include all
S	Hepatobiliary diagnostic procedures	420	Include all
		421	Include all
		422	Include all
S	Other hepatobiliary or pancreas O.R. procedures	423	Include all
		424	Include all
		425	Include all
M	Cirrhosis & alcoholic hepatitis	432	Include all
		433	Include all
		434	Include all
M	Malignancy of hepatobiliary system or pancreas	435	Include all
		436	Include all
		437	Include all
M	Disorders of pancreas except malignancy	438	Include all
		439	Include all
		440	Include all
M	Disorders of liver except malig,cirr,alc hepa	441	Include all
		442	Include all
		443	Include all
M	Disorders of the biliary tract	444	Include all
		445	Include all
		446	Include all
S	Combined anterior/posterior spinal fusion	453	Include all
		454	Include all
		455	Include all
S	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus	456	Include all
		457	Include all
		458	Include all
S	Spinal fusion except cervical	459	Include all
		460	Include all
S	Bilateral or multiple major joint procs of lower extremity	461	Include all
		462	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis	463	Include all
		464	Include all
		465	Include all
S	Revision of hip or knee replacement	466	Include all
		467	Include all
		468	Include all
S	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement	469	Include all
S	Cervical spinal fusion	471	Include all
		472	Include all
		473	Include all
S	Amputation for musculoskeletal sys & conn tissue dis	474	Include all
		475	Include all
		476	Include all
S	Biopsies of musculoskeletal system & connective tissue	477	Include all
		478	Include all
		479	Include all
S	Hip & femur procedures except major joint	480	Include all
		481	Include all
		482	Include all
S	Major joint & limb reattachment proc of upper extremity	483	Include all
S	Knee procedures w pdx of infection	485	Include all
		486	Include all
		487	Include all
S	Knee procedures w/o pdx of infection	488	Include all
		489	Include all
S	Lower extrem & humer proc except hip,foot,femur	492	Include all
		493	Include all
		494	Include all
S	Local excision & removal int fix devices exc hip & femur	495	Include all
		496	Include all
		497	Include all
S	Local excision & removal int fix devices of hip & femur	498	Include all
		499	Include all
S	Soft tissue procedures	500	Include all
		501	Include all
		502	Include all
S	Foot procedures	503	Include all
		504	Include all
		505	Include all
S	Major thumb or joint procedures	506	Include all
S	Major shoulder or elbow joint procedures	507	Include all
		508	Include all
S	Arthroscopy	509	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Shoulder,elbow or forearm proc,exc major joint proc	510	Include all
		511	Include all
		512	Include all
S	Hand or wrist proc, except major thumb or joint proc	513	Include all
		514	Include all
S	Other musculoskelet sys & conn tiss O.R. proc	515	Include all
		516	Include all
		517	Include all
S	Back & Neck Procedures Except Spinal Fusion	518	Include all
		519	Include all
		520	Include all
M	Fractures of femur	533	Include all
		534	Include all
M	Fractures of hip & pelvis	535	Include all
		536	Include all
M	Sprains, strains, & dislocations of hip, pelvis & thigh	537	Include all
		538	Include all
M	Osteomyelitis	539	Include all
		540	Include all
		541	Include all
M	Pathological fractures & musculoskelet & conn tiss malig	542	Include all
		543	Include all
		544	Include all
M	Connective tissue disorders	545	Include all
		546	Include all
		547	Include all
M	Septic arthritis	548	Include all
		549	Include all
		550	Include all
M	Medical back problems	551	Include all
		552	Include all
M	Bone diseases & arthropathies	553	Include all
		554	Include all
M	Signs & symptoms of musculoskeletal system & conn tissue	555	Include all
		556	Include all
M	Tendonitis, myositis & bursitis	557	Include all
		558	Include all
M	Aftercare, musculoskeletal system & connective tissue	559	Include all
		560	Include all
		561	Include all
M	Fx, sprn, strn & disl except femur, hip, pelvis & thigh	562	Include all
		563	Include all
M	Other musculoskeletal sys & connective tissue diagnoses	564	Include all
		565	Include all
		566	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Skin debridement	570	Include all
		571	Include all
		572	Include all
S	Skin graft for skin ulcer or cellulitis	573	Include all
		574	Include all
		575	Include all
S	Skin graft except for skin ulcer or cellulitis	576	Include all
		577	Include all
		578	Include all
S	Other skin, subcut tiss & breast proc	579	Include all
		580	Include all
		581	Include all
S	Mastectomy for malignancy	582	Include all
		583	Include all
S	Breast biopsy, local excision & other breast procedures	584	Include all
		585	Include all
M	Skin ulcers	592	Include all
		593	Include all
		594	Include all
M	Major skin disorders	595	Include all
		596	Include all
M	Malignant breast disorders	597	Include all
		598	Include all
		599	Include all
M	Non-malignant breast disorders	600	Include all
		601	Include all
M	Cellulitis	602	Include all
		603	Include all
M	Trauma to the skin, subcut tiss & breast	604	Include all
		605	Include all
M	Minor skin disorders	606	Include all
		607	Include all
S	Adrenal & pituitary procedures	614	Include all
		615	Include all
S	Amputat of lower limb for endocrine,nutrit,& metabol dis	616	Include all
		617	Include all
		618	Include all
S	O.R. procedures for obesity	619	Include all
		620	Include all
		621	Include all
S	Skin grafts & wound debrid for endoc, nutrit & metab dis	622	Include all
		623	Include all
		624	Include all
S	Thyroid, parathyroid & thyroglossal procedures	625	Include all
		626	Include all
		627	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other endocrine, nutrit & metab O.R. proc	628	Include all
		629	Include all
		630	Include all
M	Diabetes	637	Include all
		638	Include all
		639	Include all
M	Misc disorders of nutrition, metabolism, fluids/electrolyes	640	Include all
		641	Include all
M	Inborn and other disorders of metabolism	642	Include all
M	Endocrine disorders	643	Include all
		644	Include all
		645	Include all
S	Kidney transplant	652	Include all
S	Major bladder procedures	653	Include all
		654	Include all
		655	Include all
S	Kidney & ureter procedures for neoplasm	656	Include all
		657	Include all
		658	Include all
S	Kidney & ureter procedures for non-neoplasm	659	Include all
		660	Include all
		661	Include all
S	Minor bladder procedures	662	Include all
		663	Include all
		664	Include all
S	Prostatectomy	665	Include all
		666	Include all
		667	Include all
S	Transurethral procedures	668	Include all
		669	Include all
		670	Include all
S	Urethral procedures	671	Include all
		672	Include all
S	Other kidney & urinary tract procedures	673	Include all
		674	Include all
		675	Include all
M	Renal failure	682	Include all
		683	Include all
		684	Include all
M	Kidney & urinary tract neoplasms	686	Include all
		687	Include all
		688	Include all
M	Kidney & urinary tract infections	689	Include all
		690	Include all
M	Urinary stones w esw lithotripsy	691	Include all
		692	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Urinary stones w/o esw lithotripsy	693	Include all
		694	Include all
M	Kidney & urinary tract signs & symptoms	695	Include all
		696	Include all
M	Urethral stricture	697	Include all
M	Other kidney & urinary tract diagnoses	698	Include all
		699	Include all
		700	Include all
S	Major male pelvic procedures	707	Include all
		708	Include all
S	Penis procedures	709	Include all
		710	Include all
S	Testes procedures	711	Include all
		712	Include all
S	Transurethral prostatectomy	713	Include all
		714	Include all
S	Other male reproductive system O.R. proc for malignancy	715	Include all
		716	Include all
S	Other male reproductive system O.R. proc exc malignancy	717	Include all
		718	Include all
M	Malignancy, male reproductive system	722	Include all
		723	Include all
		724	Include all
M	Benign prostatic hypertrophy	725	Include all
		726	Include all
M	Inflammation of the male reproductive system	727	Include all
		728	Include all
M	Other male reproductive system diagnoses	729	Include all
		730	Include all
S	Pelvic evisceration, rad hysterectomy & rad vulvectomy	734	Include all
		735	Include all
S	Uterine & adnexa proc for ovarian or adnexal malignancy	736	Include all
		737	Include all
		738	Include all
S	Uterine,adnexa proc for non-ovarian/adnexal malig	739	Include all
		740	Include all
		741	Include all
S	Uterine & adnexa proc for non-malignancy	742	Include all
		743	Include all
S	D&C, conization, laparoscopy & tubal interruption	744	Include all
		745	Include all
S	Vagina, cervix & vulva procedures	746	Include all
		747	Include all
S	Female reproductive system reconstructive procedures	748	Include all
S	Other female reproductive system O.R. procedures	749	Include all
		750	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Malignancy, female reproductive system	754	Include all
		755	Include all
		756	Include all
M	Infections, female reproductive system	757	Include all
		758	Include all
		759	Include all
M	Menstrual & other female reproductive system disorders	760	Include all
		761	Include all
S	Splenectomy	799	Include all
		800	Include all
		801	Include all
S	Other O.R. proc of the blood & blood forming organs	802	Include all
		803	Include all
		804	Include all
M	Major hematol/immun diag exc sickle cell crisis & coagul	808	Include all
		809	Include all
		810	Include all
M	Red blood cell disorders	811	Include all
		812	Include all
M	Coagulation disorders	813	Include all
M	Reticuloendothelial & immunity disorders	814	Include all
		815	Include all
		816	Include all
S	Lymphoma & leukemia w major O.R. procedure	820	Include all
		821	Include all
		822	Include all
S	Lymphoma & non-acute leukemia w other O.R. proc	823	Include all
		824	Include all
		825	Include all
S	Myeloprolif disord or poorly diff neopl w maj O.R. proc	826	Include all
		827	Include all
		828	Include all
S	Myeloprolif disord or poorly diff neopl w other O.R. proc	829	Include all
		830	Include all
M	Acute leukemia w/o major O.R. procedure	834	Include all
		835	Include all
		836	Include all
M	Chemo w acute leukemia as sdx or w high dose chemo agent	837	Include all
		838	Include all
		839	Include all
M	Lymphoma & non-acute leukemia	840	Include all
		841	Include all
		842	Include all
M	Other myeloprolif dis or poorly diff neopl diag	843	Include all
		844	Include all
		845	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Chemotherapy w/o acute leukemia as secondary diagnosis	846	Include all
		847	Include all
		848	Include all
M	Radiotherapy	849	Include all
S	Infectious & parasitic diseases w O.R. procedure	853	Include all
		854	Include all
		855	Include all
S	Postoperative or post-traumatic infections w O.R. proc	856	Include all
		857	Include all
		858	Include all
M	Postoperative & post-traumatic infections	862	Include all
		863	Include all
M	Fever of unknown origin	864	Include all
M	Fever	865	Include all
M	Viral illness	866	Include all
M	Other infectious & parasitic diseases diagnoses	867	Include all
		868	Include all
		869	Include all
M	Septicemia or severe sepsis w MV 96+ hours	870	Include all
		871	Include all
		872	Include all
S	O.R. procedure w principal diagnoses of mental illness	876	Include all
M	Acute adjustment reaction & psychosocial dysfunction	880	Include all
M	Depressive neuroses	881	Include all
M	Neuroses except depressive	882	Include all
M	Disorders of personality & impulse control	883	Include all
M	Organic disturbances & mental retardation	884	Include all
M	Psychoses	885	Include all
M	Behavioral & developmental disorders	886	Include all
M	Other mental disorder diagnoses	887	Include all
M	Alcohol/drug abuse or dependence w rehabilitation therapy	895	Include all
		896	Include all
		897	Include all
S	Wound debridements for injuries	901	Include all
		902	Include all
		903	Include all
S	Skin grafts for injuries	904	Include all
		905	Include all
S	Hand procedures for injuries	906	Include all
S	Other O.R. procedures for injuries	907	Include all
		908	Include all
		909	Include all
M	Traumatic injury	913	Include all
		914	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Allergic reactions	915	Include all
		916	Include all
M	Poisoning & toxic effects of drugs	917	Include all
		918	Include all
M	Complications of treatment	919	Include all
		920	Include all
		921	Include all
M	Other injury, poisoning & toxic effect diag	922	Include all
		923	Include all
S	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	927	Include all
S	Full thickness burn w skin graft or inhal inj	928	Include all
		929	Include all
M	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	933	Include all
M	Full thickness burn w/o skin grft or inhal inj	934	Include all
M	Non-extensive burns	935	Include all
S	O.R. proc w diagnoses of other contact w health services	939	Include all
		940	Include all
		941	Include all
M	Rehabilitation	945	Include all
		946	Include all
M	Signs & symptoms	947	Include all
		948	Include all
M	Aftercare	949	Include all
		950	Include all
M	Other factors influencing health status	951	Include all
S	Craniotomy for multiple significant trauma	955	Include all
S	Limb reattachment, hip & femur proc for multiple significant trauma	956	Include all
S	Other O.R. procedures for multiple significant trauma	957	Include all
		958	Include all
		959	Include all
M	Other multiple significant trauma	963	Include all
		964	Include all
		965	Include all
S	HIV w extensive O.R. procedure	969	Include all
		970	Include all
M	HIV w major related condition	974	Include all
		975	Include all
		976	Include all
M	HIV w or w/o other related condition	977	Include all
S	Extensive O.R. procedure unrelated to principal diagnosis	981	Include all
		982	Include all
		983	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Geriatrics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Prostatic O.R. procedure unrelated to principal diagnosis	984	Include all
		985	Include all
		986	Include all
S	Non-extensive O.R. proc unrelated to principal diagnosis	987	Include all
		988	Include all
		989	Include all

Neurology & Neurosurgery

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Intracranial vascular procedures w PDX hemorrhage	020	Include all
		021	Include all
		022	Include all
S	Cranio w major dev impl/acute complex CNS PDX	023	Include all
		024	Include all
S	Craniotomy & endovascular intracranial procedures	025	Include all
		026	Include all
		027	Include all
S	Ventricular shunt procedures	031	Include all
		032	Include all
		033	Include all
S	Carotid artery stent procedure	034	Include all
		035	Include all
		036	Include all
S	Extracranial procedures	037	Include all
		038	Include all
		039	Include all
S	Periph & cranial nerve & other nerv syst proc	040	Include all
		041	Include all
		042	Include all
M	Spinal disorders & injuries	052	Include all
		053	Include all
M	Nervous system neoplasms	054	Include all
		055	Include all
M	Degenerative nervous system disorders	056	Include all
		057	Include all
M	Multiple sclerosis & cerebellar ataxia	058	Include all
		059	Include all
		060	Include all
M	Acute ischemic stroke w use of thrombolytic agent	061	Include all
		062	Include all
		063	Include all
M	Intracranial hemorrhage or cerebral infarction	064	Include all
		065	Include all
		066	Include all
M	Nonspecific cva & precerebral occlusion w/o infarct	067	Include all
		068	Include all
M	Transient ischemia	069	Include all

*Exclude principal diagnoses:

- T8021 (central-line-associated bloodstream infections)
- T8351 (catheter-associated urinary tract infections)

Neurology & Neurosurgery (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Nonspecific cerebrovascular disorders	070	Include all
		071	Include all
M	Cranial & peripheral nerve disorders	073	Include all
		074	Include all
M	Viral meningitis	075	Include all
		076	Include all
M	Hypertensive encephalopathy	077	Include all
		078	Include all
		079	Include all
M	Nontraumatic stupor & coma	080	Include all
		081	Include all
M	Traumatic stupor & coma, coma >1 hr	082	Include all
		083	Include all
		084	Include all
M	Traumatic stupor & coma, coma <1 hr	085	Include all
		086	Include all
		087	Include all
M	Other disorders of nervous system	091	Include all
		092	Include all
		093	Include all
M	Bacterial & tuberculous infections of nervous system	094	Include all
		095	Include all
		096	Include all
M	Non-bacterial infect of nervous sys exc viral meningitis	097	Include all
		098	Include all
		099	Include all
M	Seizures w MCC	100	Include all
S	Craniotomy for multiple significant trauma	955	Include all

Obstetrics & Gynecology

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Pelvic evisceration, rad hysterectomy & rad vulvectomy	734	Include all
		735	Include all
S	Uterine & adnexa proc for ovarian or adnexal malignancy	736	Include all
		737	Include all
		738	Include all
S	Uterine,adnexa proc for non-ovarian/adnexal malig	739	Include all
		740	Include all
		741	Include all
S	Uterine & adnexa proc for non-malignancy	742	Include all
		743	Include all
S	Vagina, cervix & vulva procedures	746	Include all
		747	Include all
S	Other female reproductive system O.R. procedures	749	Include all
		750	Include all
M	Malignancy, female reproductive system	754	Include all
		755	Include all
		756	Include all
M	Infections, female reproductive system	757	Include all
		758	Include all
		759	Include all
M	Menstrual & other female reproductive system disorders	760	Include all
		761	Include all

Orthopedics*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Spinal procedures	028	Exclude procedures: 001U074, 001U076, 001U077, 001U079, 001U0J4, 001U0J6, 001U0J7, 001U0J9, 001U0K4, 001U0K6, 001U0K7, 001U0K9, 001U374, 001U376, 001U377, 001U379, 001U3J4, 001U3J6, 001U3J7, 001U3J9, 001U3K4, 001U3K6, 001U3K7, 001U3K9, 005T0ZZ, 005T3ZZ, 005T4ZZ, 005W0ZZ, 005W3ZZ, 005W4ZZ, 005X0ZZ, 005X3ZZ, 005X4ZZ, 005Y0ZZ, 005Y3ZZ, 005Y4ZZ, 008W0ZZ, 008W3ZZ, 008W4ZZ, 008X0ZZ, 008X3ZZ, 008X4ZZ, 008Y0ZZ, 008Y3ZZ, 008Y4ZZ, 009T00Z, 009T0ZX, 009T0ZZ, 009T40Z, 009T4ZX, 009T4ZZ, 009U00Z, 009U0ZX, 009U0ZZ, 009W00Z, 009W0ZX, 009W0ZZ, 009W40Z, 009W4ZX, 009W4ZZ, 009X00Z, 009X0ZX, 009X0ZZ, 009X40Z, 009X4ZX, 009X4ZZ, 009Y00Z, 009Y0ZX, 009Y0ZZ, 009Y40Z, 009Y4ZX, 009Y4ZZ, 00BT0ZX, 00BT0ZZ, 00BT3ZX, 00BT3ZZ, 00BT4ZX, 00BT4ZZ, 00BW0ZX, 00BW0ZZ, 00BW3ZX, 00BW3ZZ, 00BW4ZX, 00BW4ZZ, 00BX0ZX, 00BX0ZZ, 00BX3ZX, 00BX3ZZ, 00BX4ZX, 00BX4ZZ, 00BY0ZX, 00BY0ZZ, 00BY3ZX, 00BY3ZZ, 00BY4ZX, 00BY4ZZ, 00CT0ZZ, 00CT3ZZ, 00CT4ZZ, 00CU0ZZ, 00CU3ZZ, 00CU4ZZ, 00CW0ZZ, 00CW3ZZ, 00CW4ZZ, 00CX0ZZ, 00CX3ZZ, 00CX4ZZ, 00CY0ZZ, 00CY3ZZ, 00CY4ZZ, 00DT0ZZ, 00DT3ZZ, 00DT4ZZ, 00FU0ZZ, 00FU3ZZ, 00FU4ZZ, 00FUXZZ, 00HU02Z, 00HU0MZ, 00HU0YZ, 00HU32Z, 00HU3MZ, 00HU42Z, 00HU4MZ, 00HV02Z, 00HV0MZ, 00HV0YZ, 00HV3MZ, 00HV3YZ, 00HV42Z, 00HV4MZ, 00HV4YZ, 00JU0ZZ, 00JU4ZZ, 00JV0ZZ, 00JV4ZZ, 00NT0ZZ, 00NT3ZZ, 00NT4ZZ, 00NW0ZZ, 00NW3ZZ, 00NW4ZZ, 00NX0ZZ, 00NX3ZZ, 00NX4ZZ, 00NY0ZZ, 00NY3ZZ, 00NY4ZZ, 00PU00Z, 00PU02Z, 00PU03Z, 00PU0JZ, 00PU0MZ, 00PU0YZ, 00PU3JZ, 00PU3MZ, 00PU40Z, 00PU42Z, 00PU43Z, 00PU4JZ, 00PU4MZ, 00PV00Z, 00PV0MZ, 00PV0YZ, 00PV3MZ, 00PV4MZ, 00QT0ZZ, 00QT3ZZ, 00QT4ZZ, 00QW0ZZ, 00QW3ZZ, 00QW4ZZ, 00QX0ZZ, 00QX3ZZ, 00QX4ZZ, 00QY0ZZ, 00QY3ZZ, 00QY4ZZ, 00RT07Z, 00RT0JZ, 00RT0KZ, 00RT47Z, 00RT4JZ, 00RT4KZ, 00SW0ZZ, 00SW3ZZ, 00SW4ZZ, 00SX0ZZ, 00SX3ZZ, 00SX4ZZ, 00SY0ZZ, 00SY3ZZ, 00SY4ZZ, 00UT07Z, 00UT0JZ, 00UT0KZ, 00UT37Z, 00UT3JZ, 00UT3KZ, 00UT47Z, 00UT4JZ, 00UT4KZ, 00WU00Z, 00WU02Z, 00WU03Z, 00WU0JZ, 00WU0MZ, 00WU0YZ, 00WU30Z, 00WU32Z, 00WU33Z, 00WU3JZ, 00WU3MZ, 00WU40Z, 00WU42Z, 00WU43Z, 00WU4JZ, 00WU4MZ, 00WV00Z, 00WV02Z, 00WV03Z, 00WV0MZ, 00WV0YZ, 00WV30Z, 00WV32Z, 00WV33Z, 00WV3MZ, 00WV40Z, 00WV42Z, 00WV43Z, 00WV4MZ, 01510ZZ, 01514ZZ, 01580ZZ, 01584ZZ, 015B0ZZ, 015B4ZZ, 015R0ZZ, 015R4ZZ, 01810ZZ, 01813ZZ, 01814ZZ, 01880ZZ, 01883ZZ, 01884ZZ, 018B0ZZ, 018B3ZZ, 018B4ZZ, 018R0ZZ, 018R3ZZ, 018R4ZZ, 0PS304Z, 0PS30ZZ, 0PS334Z, 0PS344Z, 0PS34ZZ, 0PS404Z, 0PS40ZZ, 0PS434Z, 0PS444Z, 0PS44ZZ,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Spinal procedures (cont.)	028 (cont.)	0QS004Z, 0QS00ZZ, 0QS034Z, 0QS044Z, 0QS04ZZ, 0QS104Z, 0QS10ZZ, 0QS134Z, 0QS144Z, 0QS14ZZ, 0QSS04Z, 0QSS0ZZ, 0QSS34Z, 0QSS3ZZ, 0QSS44Z, 0QSS4ZZ, 0RB00ZZ, 0RB03ZZ, 0RB04ZZ, 0RB10ZZ, 0RB13ZZ, 0RB14ZZ, 0RB40ZZ, 0RB43ZZ, 0RB44ZZ, 0RB60ZZ, 0RB63ZZ, 0RB64ZZ, 0RBA0ZZ, 0RBA3ZZ, 0RBA4ZZ, 0SB00ZZ, 0SB03ZZ, 0SB04ZZ, 0SB30ZZ, 0SB33ZZ, 0SB34ZZ, 0SB50ZZ, 0SB53ZZ, 0SB54ZZ, 0SB60ZZ, 0SB63ZZ, 0SB64ZZ, 0SB70ZZ, 0SB73ZZ, 0SB74ZZ, 0SB80ZZ, 0SB83ZZ, 0SB84ZZ
		029	See MS-DRG 028
		030	See MS-DRG 028
S	Combined anterior/posterior spinal fusion	453	Include all
		454	Include all
		455	Include all
S	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus	456	Include all
		457	Include all
		458	Include all
S	Spinal fusion except cervical	459	Include all
		460	Include all
S	Bilateral or multiple major joint procs of lower extremity	461	Include all
		462	Include all
S	Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disease	463	Include procedures: 0SP909Z, 0SP90JZ, 0SP93JZ, 0SP94JZ, 0SPA0JZ, 0SPA3JZ, 0SPA4JZ, 0SPB09Z, 0SPB0JZ, 0SPB3JZ, 0SPB4JZ, 0SPC09Z, 0SPC0JC, 0SPC0JZ, 0SPC3JC, 0SPC3JZ, 0SPC4JC, 0SPC4JZ, 0SPD09Z, 0SPD0JC, 0SPD0JZ, 0SPD3JC, 0SPD3JZ, 0SPD4JC, 0SPD4JZ, 0SPE0JZ, 0SPE3JZ, 0SPE4JZ, 0SPR0JZ, 0SPR3JZ, 0SPR4JZ, 0SPS0JZ, 0SPS3JZ, 0SPS4JZ, 0SPT0JZ, 0SPT3JZ, 0SPT4JZ, 0SPU0JZ, 0SPU3JZ, 0SPU4JZ, 0SPV0JZ, 0SPV3JZ, 0SPV4JZ, 0SPW0JZ, 0SPW3JZ, 0SPW4JZ
		464	See MS-DRG 463
		465	See MS-DRG 463
S	Revision of hip or knee replacement	466	Include all
		467	Include all
		468	Include all
S	Major joint replacement or reattachment of lower extremity	469	Include all
S	Cervical spinal fusion	471	Include all
		472	Include all
		473	Include all
S	Hip & femur procedures except major joint	480	Include all
		481	Include all
		482	Include all
S	Major joint & limb reattachment proc of upper extremity	483	Include all

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Knee procedures w pdx of infection	485	Include all
		486	Include all
		487	Include all
S	Lower extrem & humer proc except hip,foot,femur	492	Include all
		493	Include all
		494	Include all
S	Local excision & removal int fix devices exc hip & femur	495	Include all
		496	Include all
		497	Include all
S	Local excision & removal int fix devices of hip & femur	498	Include all
		499	Include all
S	Soft tissue procedures	500	Include all
		501	Include all
S	Foot procedures	503	Include all
		504	Include all
		505	Include all
S	Major thumb or joint procedures	506	Include all
S	Major shoulder or elbow joint procedures	507	Include all
		508	Include all
S	Other musculoskelet sys & conn tiss O.R. proc	515	Include procedures: 0MM00ZZ, 0MM04ZZ, 0MM10ZZ, 0MM14ZZ, 0MM20ZZ, 0MM24ZZ, 0MM30ZZ, 0MM34ZZ, 0MM40ZZ, 0MM44ZZ, 0MM50ZZ, 0MM54ZZ, 0MM60ZZ, 0MM64ZZ, 0MM70ZZ, 0MM74ZZ, 0MM80ZZ, 0MM84ZZ, 0MM90ZZ, 0MM94ZZ, 0MMB0ZZ, 0MMB4ZZ, 0MMC0ZZ, 0MMC4ZZ, 0MMD0ZZ, 0MMD4ZZ, 0MMF0ZZ, 0MMF4ZZ, 0MMG0ZZ, 0MMG4ZZ, 0MMH0ZZ, 0MMH4ZZ, 0MMJ0ZZ, 0MMJ4ZZ, 0MMK0ZZ, 0MMK4ZZ, 0MML0ZZ, 0MML4ZZ, 0MMM0ZZ, 0MMM4ZZ, 0MMN0ZZ, 0MMN4ZZ, 0MMP0ZZ, 0MMP4ZZ, 0MMQ0ZZ, 0MMQ4ZZ, 0MMR0ZZ, 0MMR4ZZ, 0MMS0ZZ, 0MMS4ZZ, 0MMT0ZZ, 0MMT4ZZ, 0MMV0ZZ, 0MMV4ZZ, 0MMW0ZZ, 0MMW4ZZ, 0MPX00Z, 0MPX0JZ, 0MPX3JZ, 0MPX40Z, 0MPX4JZ, 0MPY00Z, 0MPY0JZ, 0MPY3JZ, 0MPY40Z, 0MPY4JZ, 0MS00ZZ, 0MS04ZZ, 0MS10ZZ, 0MS14ZZ, 0MS20ZZ, 0MS24ZZ, 0MS30ZZ, 0MS34ZZ, 0MS40ZZ, 0MS44ZZ, 0MS50ZZ, 0MS54ZZ, 0MS60ZZ, 0MS64ZZ, 0MS70ZZ, 0MS74ZZ, 0MS80ZZ, 0MS84ZZ, 0MSC0ZZ, 0MSC4ZZ, 0MSD0ZZ, 0MSD4ZZ, 0MSF0ZZ, 0MSF4ZZ, 0MSG0ZZ, 0MSG4ZZ, 0MSH0ZZ, 0MSH4ZZ, 0MSJ0ZZ, 0MSJ4ZZ, 0MSK0ZZ, 0MSK4ZZ, 0MSL0ZZ, 0MSL4ZZ, 0MSM0ZZ, 0MSM4ZZ, 0MSN0ZZ, 0MSN4ZZ, 0MSP0ZZ, 0MSP4ZZ, 0MSQ0ZZ, 0MSQ4ZZ, 0MSR0ZZ, 0MSR4ZZ, 0MSS0ZZ, 0MSS4ZZ, 0MST0ZZ, 0MST4ZZ, 0MU007Z, 0MU00JZ, 0MU00KZ, 0MU047Z, 0MU04JZ, 0MU04KZ, 0MU107Z, 0MU10JZ, 0MU10KZ, 0MU147Z, 0MU14JZ, 0MU14KZ, 0MU207Z, 0MU20JZ, 0MU20KZ, 0MU247Z, 0MU24JZ, 0MU24KZ, 0MU307Z, 0MU30JZ, 0MU30KZ, 0MU347Z, 0MU34JZ, 0MU34KZ,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0MU407Z, 0MU40JZ, 0MU40KZ, 0MU447Z, 0MU44JZ, 0MU44KZ, 0MU507Z, 0MU50JZ, 0MU50KZ, 0MU547Z, 0MU54JZ, 0MU54KZ, 0MU607Z, 0MU60JZ, 0MU60KZ, 0MU647Z, 0MU64JZ, 0MU64KZ, 0MU707Z, 0MU70JZ, 0MU70KZ, 0MU747Z, 0MU74JZ, 0MU74KZ, 0MU807Z, 0MU80JZ, 0MU80KZ, 0MU847Z, 0MU84JZ, 0MU84KZ, 0MUC07Z, 0MUC0JZ, 0MUC0KZ, 0MUC47Z, 0MUC4JZ, 0MUC4KZ, 0MUD07Z, 0MUD0JZ, 0MUD0KZ, 0MUD47Z, 0MUD4JZ, 0MUD4KZ, 0MUF07Z, 0MUF0JZ, 0MUF0KZ, 0MUF47Z, 0MUF4JZ, 0MUF4KZ, 0MUG07Z, 0MUG0JZ, 0MUG0KZ, 0MUG47Z, 0MUG4JZ, 0MUG4KZ, 0MUH07Z, 0MUH0JZ, 0MUH0KZ, 0MUH47Z, 0MUH4JZ, 0MUH4KZ, 0MUJ07Z, 0MUJ0JZ, 0MUJ0KZ, 0MUJ47Z, 0MUJ4JZ, 0MUJ4KZ, 0MUK07Z, 0MUK0JZ, 0MUK0KZ, 0MUK47Z, 0MUK4JZ, 0MUK4KZ, 0MUL07Z, 0MUL0JZ, 0MUL0KZ, 0MUL47Z, 0MUL4JZ, 0MUL4KZ, 0MUM07Z, 0MUM0JZ, 0MUM0KZ, 0MUM47Z, 0MUM4JZ, 0MUM4KZ, 0MUN07Z, 0MUN0JZ, 0MUN0KZ, 0MUN47Z, 0MUN4JZ, 0MUN4KZ, 0MUP07Z, 0MUP0JZ, 0MUP0KZ, 0MUP47Z, 0MUP4JZ, 0MUP4KZ, 0MUQ07Z, 0MUQ0JZ, 0MUQ0KZ, 0MUQ47Z, 0MUQ4JZ, 0MUQ4KZ, 0MUR07Z, 0MUR0JZ, 0MUR0KZ, 0MUR47Z, 0MUR4JZ, 0MUR4KZ, 0MUS07Z, 0MUS0JZ, 0MUS0KZ, 0MUS47Z, 0MUS4JZ, 0MUS4KZ, 0MUT07Z, 0MUT0JZ, 0MUT0KZ, 0MUT47Z, 0MUT4JZ, 0MUT4KZ, 0NBC0ZZ, 0NBC3ZZ, 0NBC4ZZ, 0NBF0ZZ, 0NBF3ZZ, 0NBF4ZZ, 0NBG0ZZ, 0NBG3ZZ, 0NBG4ZZ, 0NBH0ZZ, 0NBH3ZZ, 0NBH4ZZ, 0NBJ0ZZ, 0NBJ3ZZ, 0NBJ4ZZ, 0NBK0ZZ, 0NBK3ZZ, 0NBK4ZZ, 0NBL0ZZ, 0NBL3ZZ, 0NBL4ZZ, 0NBM0ZZ, 0NBM3ZZ, 0NBM4ZZ, 0NBN0ZZ, 0NBN3ZZ, 0NBN4ZZ, 0NBR0ZZ, 0NBR3ZZ, 0NBR4ZZ, 0NBT0ZZ, 0NBT3ZZ, 0NBT4ZZ, 0NBV0ZZ, 0NBV3ZZ, 0NBV4ZZ, 0NBX0ZZ, 0NBX3ZZ, 0NBX4ZZ, 0NQR0ZZ, 0NQR3ZZ, 0NQR4ZZ, 0NQT0ZZ, 0NQT3ZZ, 0NQT4ZZ, 0NQV0ZZ, 0NQV3ZZ, 0NQV4ZZ, 0NRC0JZ, 0NRC3JZ, 0NRC47Z, 0NRF0JZ, 0NRF3JZ, 0NRF4JZ, 0NRG0JZ, 0NRG0KZ, 0NRG3JZ, 0NRG4JZ, 0NRH0JZ, 0NRH3JZ, 0NRH4JZ, 0NRJ0JZ, 0NRJ3JZ, 0NRJ4JZ, 0NRK0JZ, 0NRK3JZ, 0NRK4JZ, 0NRL0JZ, 0NRL3JZ, 0NRL4JZ, 0NRM0JZ, 0NRM3JZ, 0NRM4JZ, 0NRN0JZ, 0NRN3JZ, 0NRN4JZ, 0NRT07Z, 0NRT0JZ, 0NRT0KZ, 0NRT37Z, 0NRT3JZ, 0NRT3KZ, 0NRT47Z, 0NRT4JZ, 0NRT4KZ, 0NRV07Z, 0NRV0JZ, 0NRV0KZ, 0NRV37Z, 0NRV3JZ, 0NRV3KZ, 0NRV47Z, 0NRV4JZ, 0NRV4KZ, 0NRX0JZ, 0NRX3JZ, 0NRX4JZ, 0NSC04Z, 0NSC0ZZ, 0NSF04Z, 0NSF0ZZ, 0NSG04Z, 0NSG0ZZ, 0NSH04Z, 0NSH0ZZ, 0NSJ04Z, 0NSJ0ZZ, 0NSK04Z, 0NSK0ZZ, 0NSL04Z, 0NSL0ZZ, 0NSM04Z, 0NSM0ZZ, 0NSN04Z, 0NSN0ZZ, 0NSP04Z, 0NSP0ZZ, 0NSQ04Z, 0NSQ0ZZ, 0NSR04Z,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0NSR05Z, 0NSR0ZZ, 0NST04Z, 0NST05Z, 0NST0ZZ, 0NSV04Z, 0NSV05Z, 0NSV0ZZ, 0NSX04Z, 0NSX0ZZ, 0NTC0ZZ, 0NTF0ZZ, 0NTG0ZZ, 0NTH0ZZ, 0NTJ0ZZ, 0NTK0ZZ, 0NTL0ZZ, 0NTM0ZZ, 0NTN0ZZ, 0NTP0ZZ, 0NTQ0ZZ, 0NTR0ZZ, 0NTT0ZZ, 0NTV0ZZ, 0NTX0ZZ, 0NUC07Z, 0NUC0JZ, 0NUC3JZ, 0NUC4JZ, 0NUF0JZ, 0NUF3JZ, 0NUF4JZ, 0NUG0JZ, 0NUG3JZ, 0NUG4JZ, 0NUH0JZ, 0NUH3JZ, 0NUH4JZ, 0NUJ0JZ, 0NUJ3JZ, 0NUJ4JZ, 0NUK0JZ, 0NUK3JZ, 0NUK4JZ, 0NUL0JZ, 0NUL3JZ, 0NUL4JZ, 0NUM0JZ, 0NUM3JZ, 0NUM4JZ, 0NUN0JZ, 0NUN3JZ, 0NUN4JZ, 0NUT07Z, 0NUT0JZ, 0NUT0KZ, 0NUT37Z, 0NUT3JZ, 0NUT3KZ, 0NUT47Z, 0NUT4JZ, 0NUT4KZ, 0NUV07Z, 0NUV0JZ, 0NUV0KZ, 0NUV37Z, 0NUV3JZ, 0NUV3KZ, 0NUV47Z, 0NUV4JZ, 0NUV4KZ, 0NUX07Z, 0NUX0JZ, 0NUX3JZ, 0NUX4JZ, 0P800ZZ, 0P803ZZ, 0P804ZZ, 0P810ZZ, 0P813ZZ, 0P814ZZ, 0P820ZZ, 0P823ZZ, 0P824ZZ, 0P830ZZ, 0P833ZZ, 0P834ZZ, 0P840ZZ, 0P843ZZ, 0P844ZZ, 0P850ZZ, 0P853ZZ, 0P854ZZ, 0P860ZZ, 0P863ZZ, 0P864ZZ, 0P870ZZ, 0P873ZZ, 0P874ZZ, 0P880ZZ, 0P883ZZ, 0P884ZZ, 0P890ZZ, 0P893ZZ, 0P894ZZ, 0P8B0ZZ, 0P8B3ZZ, 0P8B4ZZ, 0P8R0ZZ, 0P8R3ZZ, 0P8R4ZZ, 0P8S0ZZ, 0P8S3ZZ, 0P8S4ZZ, 0P8T0ZZ, 0P8T3ZZ, 0P8T4ZZ, 0P8V0ZZ, 0P8V3ZZ, 0P8V4ZZ, 0PB00ZZ, 0PB03ZZ, 0PB04ZZ, 0PB10ZZ, 0PB13ZZ, 0PB14ZZ, 0PB20ZZ, 0PB23ZZ, 0PB24ZZ, 0PB30ZZ, 0PB33ZZ, 0PB34ZZ, 0PB40ZZ, 0PB43ZZ, 0PB44ZZ, 0PB50ZZ, 0PB53ZZ, 0PB54ZZ, 0PB60ZZ, 0PB63ZZ, 0PB64ZZ, 0PB70ZZ, 0PB73ZZ, 0PB74ZZ, 0PB80ZZ, 0PB83ZZ, 0PB84ZZ, 0PB90ZZ, 0PB93ZZ, 0PB94ZZ, 0PBB0ZZ, 0PBB3ZZ, 0PBB4ZZ, 0PBR0ZZ, 0PBR3ZZ, 0PBR4ZZ, 0PBS0ZZ, 0PBS3ZZ, 0PBS4ZZ, 0PBT0ZZ, 0PBT3ZZ, 0PBT4ZZ, 0PBV0ZZ, 0PBV3ZZ, 0PBV4ZZ, 0PC00ZZ, 0PC03ZZ, 0PC04ZZ, 0PC10ZZ, 0PC13ZZ, 0PC14ZZ, 0PC20ZZ, 0PC23ZZ, 0PC24ZZ, 0PC30ZZ, 0PC33ZZ, 0PC34ZZ, 0PC40ZZ, 0PC43ZZ, 0PC44ZZ, 0PC50ZZ, 0PC53ZZ, 0PC54ZZ, 0PC60ZZ, 0PC63ZZ, 0PC64ZZ, 0PC70ZZ, 0PC73ZZ, 0PC74ZZ, 0PC80ZZ, 0PC83ZZ, 0PC84ZZ, 0PC90ZZ, 0PC93ZZ, 0PC94ZZ, 0PCB0ZZ, 0PCB3ZZ, 0PCB4ZZ, 0PCR0ZZ, 0PCR3ZZ, 0PCR4ZZ, 0PCS0ZZ, 0PCS3ZZ, 0PCS4ZZ, 0PCT0ZZ, 0PCT3ZZ, 0PCT4ZZ, 0PCV0ZZ, 0PCV3ZZ, 0PCV4ZZ, 0PH000Z, 0PH004Z, 0PH030Z, 0PH034Z, 0PH040Z, 0PH044Z, 0PH104Z, 0PH134Z, 0PH144Z, 0PH204Z, 0PH234Z, 0PH244Z, 0PH304Z, 0PH334Z, 0PH344Z, 0PH404Z, 0PH434Z, 0PH444Z, 0PH504Z, 0PH534Z, 0PH544Z, 0PH604Z, 0PH634Z, 0PH644Z, 0PH704Z, 0PH734Z, 0PH744Z, 0PH804Z, 0PH834Z, 0PH844Z, 0PH904Z, 0PH934Z, 0PH944Z, 0PHB04Z, 0PHB34Z, 0PHB44Z, 0PHR04Z, 0PHR05Z, 0PHR34Z, 0PHR35Z, 0PHR44Z, 0PHR45Z, 0PHS04Z, 0PHS05Z, 0PHS34Z, 0PHS35Z, 0PHS44Z,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0PHS45Z, 0PHT04Z, 0PHT05Z, 0PHT34Z, 0PHT35Z, 0PHT44Z, 0PHT45Z, 0PHV04Z, 0PHV05Z, 0PHV34Z, 0PHV35Z, 0PHV44Z, 0PHV45Z, 0PHY0MZ, 0PHY3MZ, 0PHY4MZ, 0PN00ZZ, 0PN03ZZ, 0PN04ZZ, 0PN10ZZ, 0PN13ZZ, 0PN14ZZ, 0PN20ZZ, 0PN23ZZ, 0PN24ZZ, 0PN30ZZ, 0PN33ZZ, 0PN34ZZ, 0PN40ZZ, 0PN43ZZ, 0PN44ZZ, 0PN50ZZ, 0PN53ZZ, 0PN54ZZ, 0PN60ZZ, 0PN63ZZ, 0PN64ZZ, 0PN70ZZ, 0PN73ZZ, 0PN74ZZ, 0PN80ZZ, 0PN83ZZ, 0PN84ZZ, 0PN90ZZ, 0PN93ZZ, 0PN94ZZ, 0PNB0ZZ, 0PNB3ZZ, 0PNB4ZZ, 0PNR0ZZ, 0PNR3ZZ, 0PNR4ZZ, 0PNS0ZZ, 0PNS3ZZ, 0PNS4ZZ, 0PNT0ZZ, 0PNT3ZZ, 0PNT4ZZ, 0PNV0ZZ, 0PNV3ZZ, 0PNV4ZZ, 0PQ00ZZ, 0PQ03ZZ, 0PQ04ZZ, 0PQ10ZZ, 0PQ13ZZ, 0PQ14ZZ, 0PQ20ZZ, 0PQ23ZZ, 0PQ24ZZ, 0PQ30ZZ, 0PQ33ZZ, 0PQ34ZZ, 0PQ40ZZ, 0PQ43ZZ, 0PQ44ZZ, 0PQ50ZZ, 0PQ53ZZ, 0PQ54ZZ, 0PQ60ZZ, 0PQ63ZZ, 0PQ64ZZ, 0PQ70ZZ, 0PQ73ZZ, 0PQ74ZZ, 0PQ80ZZ, 0PQ83ZZ, 0PQ84ZZ, 0PQ90ZZ, 0PQ93ZZ, 0PQ94ZZ, 0PQB0ZZ, 0PQB3ZZ, 0PQB4ZZ, 0PQR0ZZ, 0PQR3ZZ, 0PQR4ZZ, 0PQS0ZZ, 0PQS3ZZ, 0PQS4ZZ, 0PQT0ZZ, 0PQT3ZZ, 0PQT4ZZ, 0PQV0ZZ, 0PQV3ZZ, 0PQV4ZZ, 0PR007Z, 0PR00JZ, 0PR00KZ, 0PR037Z, 0PR03JZ, 0PR03KZ, 0PR047Z, 0PR04JZ, 0PR04KZ, 0PR107Z, 0PR10JZ, 0PR10KZ, 0PR137Z, 0PR13JZ, 0PR13KZ, 0PR147Z, 0PR14JZ, 0PR14KZ, 0PR207Z, 0PR20JZ, 0PR20KZ, 0PR237Z, 0PR23JZ, 0PR23KZ, 0PR247Z, 0PR24JZ, 0PR24KZ, 0PR307Z, 0PR30JZ, 0PR30KZ, 0PR337Z, 0PR33JZ, 0PR33KZ, 0PR347Z, 0PR34JZ, 0PR34KZ, 0PR407Z, 0PR40JZ, 0PR40KZ, 0PR437Z, 0PR43JZ, 0PR43KZ, 0PR447Z, 0PR44JZ, 0PR44KZ, 0PR507Z, 0PR50JZ, 0PR50KZ, 0PR537Z, 0PR53JZ, 0PR53KZ, 0PR547Z, 0PR54JZ, 0PR54KZ, 0PR607Z, 0PR60JZ, 0PR60KZ, 0PR637Z, 0PR63JZ, 0PR63KZ, 0PR647Z, 0PR64JZ, 0PR64KZ, 0PR707Z, 0PR70JZ, 0PR70KZ, 0PR737Z, 0PR73JZ, 0PR73KZ, 0PR747Z, 0PR74JZ, 0PR74KZ, 0PR807Z, 0PR80JZ, 0PR80KZ, 0PR837Z, 0PR83JZ, 0PR83KZ, 0PR847Z, 0PR84JZ, 0PR84KZ, 0PR907Z, 0PR90JZ, 0PR90KZ, 0PR937Z, 0PR93JZ, 0PR93KZ, 0PR947Z, 0PR94JZ, 0PR94KZ, 0PRB07Z, 0PRB0JZ, 0PRB0KZ, 0PRB37Z, 0PRB3JZ, 0PRB3KZ, 0PRB47Z, 0PRB4JZ, 0PRB4KZ, 0PRR07Z, 0PRR0JZ, 0PRR0KZ, 0PRR37Z, 0PRR3JZ, 0PRR3KZ, 0PRR47Z, 0PRR4JZ, 0PRR4KZ, 0PRS07Z, 0PRS0JZ, 0PRS0KZ, 0PRS37Z, 0PRS3JZ, 0PRS3KZ, 0PRS47Z, 0PRS4JZ, 0PRS4KZ, 0PRT07Z, 0PRT0JZ, 0PRT0KZ, 0PRT37Z, 0PRT3JZ, 0PRT3KZ, 0PRT47Z, 0PRT4JZ, 0PRT4KZ, 0PRV07Z, 0PRV0JZ, 0PRV0KZ, 0PRV37Z, 0PRV3JZ, 0PRV3KZ, 0PRV47Z, 0PRV4JZ, 0PRV4KZ, 0PS000Z, 0PS004Z, 0PS00ZZ, 0PS030Z, 0PS034Z, 0PS040Z, 0PS044Z, 0PS104Z, 0PS10ZZ, 0PS134Z, 0PS144Z, 0PS204Z, 0PS20ZZ, 0PS234Z, 0PS244Z, 0PS334Z,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0PS33ZZ, 0PS43ZZ, 0PS504Z, 0PS50ZZ, 0PS534Z, 0PS544Z, 0PS604Z, 0PS60ZZ, 0PS634Z, 0PS644Z, 0PS704Z, 0PS70ZZ, 0PS734Z, 0PS744Z, 0PS804Z, 0PS80ZZ, 0PS834Z, 0PS844Z, 0PS904Z, 0PS90ZZ, 0PS934Z, 0PS944Z, 0PSB04Z, 0PSB0ZZ, 0PSB34Z, 0PSB44Z, 0PSR05Z, 0PSR35Z, 0PSR45Z, 0PSS05Z, 0PSS35Z, 0PSS45Z, 0PST05Z, 0PST35Z, 0PST45Z, 0PSV05Z, 0PSV35Z, 0PSV45Z, 0PT00ZZ, 0PT10ZZ, 0PT20ZZ, 0PT50ZZ, 0PT60ZZ, 0PT70ZZ, 0PT80ZZ, 0PT90ZZ, 0PTB0ZZ, 0PTR0ZZ, 0PTS0ZZ, 0PTT0ZZ, 0PTV0ZZ, 0PU007Z, 0PU00JZ, 0PU00KZ, 0PU037Z, 0PU03JZ, 0PU03KZ, 0PU047Z, 0PU04JZ, 0PU04KZ, 0PU107Z, 0PU10JZ, 0PU10KZ, 0PU137Z, 0PU13JZ, 0PU13KZ, 0PU147Z, 0PU14JZ, 0PU14KZ, 0PU207Z, 0PU20JZ,0PU20KZ, 0PU237Z, 0PU23JZ, 0PU23KZ, 0PU247Z, 0PU24JZ, 0PU24KZ, 0PU307Z, 0PU30JZ, 0PU30KZ, 0PU337Z, 0PU33JZ, 0PU33KZ, 0PU347Z, 0PU34JZ, 0PU34KZ, 0PU407Z, 0PU40JZ, 0PU40KZ, 0PU437Z, 0PU43JZ, 0PU43KZ, 0PU447Z, 0PU44JZ, 0PU44KZ, 0PU507Z, 0PU50JZ, 0PU50KZ, 0PU537Z, 0PU53JZ, 0PU53KZ, 0PU547Z, 0PU54JZ, 0PU54KZ, 0PU607Z, 0PU60JZ, 0PU60KZ, 0PU637Z, 0PU63JZ, 0PU63KZ, 0PU647Z, 0PU64JZ, 0PU64KZ, 0PU707Z, 0PU70JZ, 0PU70KZ, 0PU737Z, 0PU73JZ, 0PU73KZ, 0PU747Z, 0PU74JZ, 0PU74KZ, 0PU807Z, 0PU80JZ, 0PU80KZ, 0PU837Z, 0PU83JZ, 0PU83KZ, 0PU847Z, 0PU84JZ, 0PU84KZ, 0PU907Z, 0PU90JZ, 0PU90KZ, 0PU937Z, 0PU93JZ, 0PU93KZ, 0PU947Z, 0PU94JZ, 0PU94KZ, 0PUB07Z, 0PUB0JZ, 0PUB0KZ, 0PUB37Z, 0PUB3JZ, 0PUB3KZ, 0PUB47Z, 0PUB4JZ, 0PUB4KZ, 0PUR07Z, 0PUR0JZ, 0PUR0KZ, 0PUR37Z, 0PUR3JZ, 0PUR3KZ, 0PUR47Z, 0PUR4JZ, 0PUR4KZ, 0PUS07Z, 0PUS0JZ, 0PUS0KZ, 0PUS37Z, 0PUS3JZ, 0PUS3KZ, 0PUS47Z, 0PUS4JZ, 0PUS4KZ, 0PUT07Z, 0PUT0JZ, 0PUT0KZ, 0PUT37Z, 0PUT3JZ, 0PUT3KZ, 0PUT47Z, 0PUT4JZ, 0PUT4KZ, 0PUV07Z, 0PUV0JZ, 0PUV0KZ, 0PUV37Z, 0PUV3JZ, 0PUV3KZ, 0PUV47Z, 0PUV4JZ, 0PUV4KZ, 0Q800ZZ, 0Q803ZZ, 0Q804ZZ, 0Q810ZZ, 0Q813ZZ, 0Q814ZZ, 0Q820ZZ, 0Q823ZZ, 0Q824ZZ, 0Q830ZZ, 0Q833ZZ, 0Q834ZZ, 0Q840ZZ, 0Q843ZZ, 0Q844ZZ, 0Q850ZZ, 0Q853ZZ, 0Q854ZZ, 0Q8Q0ZZ, 0Q8Q3ZZ, 0Q8Q4ZZ, 0Q8R0ZZ, 0Q8R3ZZ, 0Q8R4ZZ, 0Q8S0ZZ, 0Q8S3ZZ, 0Q8S4ZZ, 0QB00ZZ, 0QB03ZZ, 0QB04ZZ, 0QB10ZZ, 0QB13ZZ, 0QB14ZZ, 0QB20ZZ, 0QB23ZZ, 0QB24ZZ, 0QB30ZZ, 0QB33ZZ, 0QB34ZZ, 0QB40ZZ, 0QB43ZZ, 0QB44ZZ, 0QB50ZZ, 0QB53ZZ, 0QB54ZZ, 0QBQ0ZZ, 0QBQ3ZZ, 0QBQ4ZZ, 0QBR0ZZ, 0QBR3ZZ, 0QBR4ZZ, 0QBS0ZZ, 0QBS3ZZ, 0QBS4ZZ, 0QC00ZZ, 0QC03ZZ, 0QC04ZZ, 0QC10ZZ, 0QC13ZZ, 0QC14ZZ, 0QC20ZZ, 0QC23ZZ, 0QC24ZZ, 0QC30ZZ, 0QC33ZZ, 0QC34ZZ, 0QC40ZZ, 0QC43ZZ, 0QC44ZZ, 0QC50ZZ, 0QC53ZZ, 0QC54ZZ, 0QCQ0ZZ, 0QCQ3ZZ, 0QCQ4ZZ, 0QCR0ZZ, 0QCR3ZZ, 0QCR4ZZ,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0QCS0ZZ, 0QCS3ZZ, 0QCS4ZZ, 0QH004Z, 0QH005Z, 0QH034Z, 0QH035Z, 0QH044Z, 0QH045Z, 0QH104Z, 0QH105Z, 0QH134Z, 0QH135Z, 0QH144Z, 0QH145Z, 0QH204Z, 0QH205Z, 0QH234Z, 0QH235Z, 0QH244Z, 0QH245Z, 0QH304Z, 0QH305Z, 0QH334Z, 0QH335Z, 0QH344Z, 0QH345Z, 0QH404Z, 0QH405Z, 0QH434Z, 0QH435Z, 0QH444Z, 0QH445Z, 0QH504Z, 0QH505Z, 0QH534Z, 0QH535Z, 0QH544Z, 0QH545Z, 0QHQ04Z, 0QHQ05Z, 0QHQ34Z, 0QHQ35Z, 0QHQ44Z, 0QHQ45Z, 0QHR04Z, 0QHR05Z, 0QHR34Z, 0QHR35Z, 0QHR44Z, 0QHR45Z, 0QHS04Z, 0QHS05Z, 0QHS34Z, 0QHS35Z, 0QHS44Z, 0QHS45Z, 0QHY0MZ, 0QHY3MZ, 0QHY4MZ, 0QN00ZZ, 0QN03ZZ, 0QN04ZZ, 0QN10ZZ, 0QN13ZZ, 0QN14ZZ, 0QN20ZZ, 0QN23ZZ, 0QN24ZZ, 0QN30ZZ, 0QN33ZZ, 0QN34ZZ, 0QN40ZZ, 0QN43ZZ, 0QN44ZZ, 0QN50ZZ, 0QN53ZZ, 0QN54ZZ, 0QNQ0ZZ, 0QNQ3ZZ, 0QNQ4ZZ, 0QNR0ZZ, 0QNR3ZZ, 0QNR4ZZ, 0QNS0ZZ, 0QNS3ZZ, 0QNS4ZZ, 0QQ00ZZ, 0QQ03ZZ, 0QQ04ZZ, 0QQ10ZZ, 0QQ13ZZ, 0QQ14ZZ, 0QQ20ZZ, 0QQ23ZZ, 0QQ24ZZ, 0QQ30ZZ, 0QQ33ZZ, 0QQ34ZZ, 0QQ40ZZ, 0QQ43ZZ, 0QQ44ZZ, 0QQ50ZZ, 0QQ53ZZ, 0QQ54ZZ, 0QQD3ZZ, 0QQF3ZZ, 0QQQ0ZZ, 0QQQ3ZZ, 0QQQ4ZZ, 0QQR0ZZ, 0QQR3ZZ, 0QQR4ZZ, 0QQS0ZZ, 0QQS3ZZ, 0QQS4ZZ, 0QR007Z, 0QR00JZ, 0QR00KZ, 0QR037Z, 0QR03JZ, 0QR03KZ, 0QR047Z, 0QR04JZ, 0QR04KZ, 0QR107Z, 0QR10JZ, 0QR10KZ, 0QR137Z, 0QR13JZ, 0QR13KZ, 0QR147Z, 0QR14JZ, 0QR14KZ, 0QR207Z, 0QR20JZ, 0QR20KZ, 0QR237Z, 0QR23JZ, 0QR23KZ, 0QR247Z, 0QR24JZ, 0QR24KZ, 0QR307Z, 0QR30JZ, 0QR30KZ, 0QR337Z, 0QR33JZ, 0QR33KZ, 0QR347Z, 0QR34JZ, 0QR34KZ, 0QR407Z, 0QR40JZ, 0QR40KZ, 0QR437Z, 0QR43JZ, 0QR43KZ, 0QR447Z, 0QR44JZ, 0QR44KZ, 0QR507Z, 0QR50JZ, 0QR50KZ, 0QR537Z, 0QR53JZ, 0QR53KZ, 0QR547Z, 0QR54JZ, 0QR54KZ, 0QRQ07Z, 0QRQ0JZ, 0QRQ0KZ, 0QRQ37Z, 0QRQ3JZ, 0QRQ3KZ, 0QRQ47Z, 0QRQ4JZ, 0QRQ4KZ, 0QRR07Z, 0QRR0JZ, 0QRR0KZ, 0QRR37Z, 0QRR3JZ, 0QRR3KZ, 0QRR47Z, 0QRR4JZ, 0QRR4KZ, 0QRS07Z, 0QRS0JZ, 0QRS0KZ, 0QRS37Z, 0QRS3JZ, 0QRS3KZ, 0QRS47Z, 0QRS4JZ, 0QRS4KZ, 0QS03ZZ, 0QS13ZZ, 0QS204Z, 0QS205Z, 0QS20ZZ, 0QS234Z, 0QS235Z, 0QS244Z, 0QS245Z, 0QS304Z, 0QS305Z, 0QS30ZZ, 0QS334Z, 0QS335Z, 0QS344Z, 0QS345Z, 0QS404Z, 0QS40ZZ, 0QS434Z, 0QS444Z, 0QS504Z, 0QS50ZZ, 0QS534Z, 0QS544Z, 0QSD04Z, 0QSD0ZZ, 0QSD34Z, 0QSD44Z, 0QSF04Z, 0QSF0ZZ, 0QSF34Z, 0QSF44Z, 0QSQ05Z, 0QSQ35Z, 0QSQ45Z, 0QSR05Z, 0QSR35Z, 0QSR45Z, 0QT20ZZ, 0QT30ZZ, 0QT40ZZ, 0QT50ZZ, 0QTQ0ZZ,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0QTR0ZZ, 0QTS0ZZ, 0QU007Z, 0QU00JZ, 0QU00KZ, 0QU037Z, 0QU03JZ, 0QU03KZ, 0QU047Z, 0QU04JZ, 0QU04KZ, 0QU107Z, 0QU10JZ, 0QU10KZ, 0QU137Z, 0QU13JZ, 0QU13KZ, 0QU147Z, 0QU14JZ, 0QU14KZ, 0QU207Z, 0QU20JZ, 0QU20KZ, 0QU237Z, 0QU23JZ, 0QU23KZ, 0QU247Z, 0QU24JZ, 0QU24KZ, 0QU307Z, 0QU30JZ, 0QU30KZ, 0QU337Z, 0QU33JZ, 0QU33KZ, 0QU347Z, 0QU34JZ, 0QU34KZ, 0QU407Z, 0QU40JZ, 0QU40KZ, 0QU437Z, 0QU43JZ, 0QU43KZ, 0QU447Z, 0QU44JZ, 0QU44KZ, 0QU507Z, 0QU50JZ, 0QU50KZ, 0QU537Z, 0QU53JZ, 0QU53KZ, 0QU547Z, 0QU54JZ, 0QU54KZ, 0QUQ07Z, 0QUQ0JZ, 0QUQ0KZ, 0QUQ37Z, 0QUQ3JZ, 0QUQ3KZ, 0QUQ47Z, 0QUQ4JZ, 0QUQ4KZ, 0QUR07Z, 0QUR0JZ, 0QUR0KZ, 0QUR37Z, 0QUR3JZ, 0QUR3KZ, 0QUR47Z, 0QUR4JZ, 0QUR4KZ, 0QUS07Z, 0QUS0JZ, 0QUS0KZ, 0QUS37Z, 0QUS3JZ, 0QUS3KZ, 0QUS47Z, 0QUS4JZ, 0QUS4KZ, 0R9000Z, 0R900ZZ, 0R9100Z, 0R910ZZ, 0R9300Z, 0R930ZZ, 0R9400Z, 0R940ZZ, 0R9500Z, 0R950ZZ, 0R9600Z, 0R960ZZ, 0R9900Z, 0R990ZZ, 0R9A00Z, 0R9A0ZZ, 0R9B00Z, 0R9B0ZZ, 0RC00ZZ, 0RC03ZZ, 0RC04ZZ, 0RC10ZZ, 0RC13ZZ, 0RC14ZZ, 0RC30ZZ, 0RC33ZZ, 0RC34ZZ, 0RC40ZZ, 0RC43ZZ, 0RC44ZZ, 0RC50ZZ, 0RC53ZZ, 0RC54ZZ, 0RC60ZZ, 0RC63ZZ, 0RC64ZZ, 0RC90ZZ, 0RC93ZZ, 0RC94ZZ, 0RCA0ZZ, 0RCA3ZZ, 0RCA4ZZ, 0RCB0ZZ, 0RCB3ZZ, 0RCB4ZZ, 0RCC0ZZ, 0RCC3ZZ, 0RCC4ZZ, 0RCD0ZZ, 0RCD3ZZ, 0RCD4ZZ, 0RGC04Z, 0RGC07Z, 0RGC0JZ, 0RGC0KZ, 0RGC0ZZ, 0RGC34Z, 0RGC37Z, 0RGC3JZ, 0RGC3KZ, 0RGC3ZZ, 0RGC44Z, 0RGC47Z, 0RGC4JZ, 0RGC4KZ, 0RGC4ZZ, 0RGD04Z, 0RGD07Z, 0RGD0JZ, 0RGD0KZ, 0RGD0ZZ, 0RGD34Z, 0RGD37Z, 0RGD3JZ, 0RGD3KZ, 0RGD3ZZ, 0RGD44Z, 0RGD47Z, 0RGD4JZ, 0RGD4KZ, 0RGD4ZZ, 0RH004Z, 0RH034Z, 0RH044Z, 0RH104Z, 0RH134Z, 0RH144Z, 0RH404Z, 0RH434Z, 0RH444Z, 0RH604Z, 0RH634Z, 0RH644Z, 0RHA04Z, 0RHA34Z, 0RHA44Z, 0RJ00ZZ, 0RJ10ZZ, 0RJ30ZZ, 0RJ40ZZ, 0RJ50ZZ, 0RJ60ZZ, 0RJ90ZZ, 0RJA0ZZ, 0RJB0ZZ, 0RP000Z, 0RP003Z, 0RP004Z, 0RP007Z, 0RP00AZ, 0RP00KZ, 0RP034Z, 0RP037Z, 0RP03AZ, 0RP03KZ, 0RP040Z, 0RP043Z, 0RP044Z, 0RP047Z, 0RP04AZ, 0RP04KZ, 0RP100Z, 0RP103Z, 0RP104Z, 0RP107Z, 0RP10AZ, 0RP10KZ, 0RP134Z, 0RP137Z, 0RP13AZ, 0RP13KZ, 0RP140Z, 0RP143Z, 0RP144Z, 0RP147Z, 0RP14AZ, 0RP14KZ, 0RP300Z, 0RP303Z, 0RP307Z, 0RP30KZ, 0RP337Z, 0RP33KZ, 0RP340Z, 0RP343Z, 0RP347Z, 0RP34KZ, 0RP400Z, 0RP403Z, 0RP404Z, 0RP407Z, 0RP40AZ, 0RP40KZ, 0RP434Z, 0RP437Z, 0RP43AZ, 0RP43KZ, 0RP440Z, 0RP443Z, 0RP444Z, 0RP447Z,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0RP44AZ, 0RP44KZ, 0RP500Z, 0RP503Z, 0RP507Z, 0RP50KZ, 0RP537Z, 0RP53KZ, 0RP540Z, 0RP543Z, 0RP547Z, 0RP54KZ, 0RP600Z, 0RP603Z, 0RP604Z, 0RP607Z, 0RP60AZ, 0RP60KZ, 0RP634Z, 0RP637Z, 0RP63AZ, 0RP63KZ, 0RP640Z, 0RP643Z, 0RP644Z, 0RP647Z, 0RP64AZ, 0RP64KZ, 0RP900Z, 0RP903Z, 0RP907Z, 0RP90KZ, 0RP937Z, 0RP93KZ, 0RP940Z, 0RP943Z, 0RP947Z, 0RP94KZ, 0RPA00Z, 0RPA03Z, 0RPA04Z, 0RPA07Z, 0RPA0AZ, 0RPA0KZ, 0RPA34Z, 0RPA37Z, 0RPA3AZ, 0RPA3KZ, 0RPA40Z, 0RPA43Z, 0RPA44Z, 0RPA47Z, 0RPA4AZ, 0RPA4KZ, 0RPB00Z, 0RPB03Z, 0RPB07Z, 0RPB0KZ, 0RPB37Z, 0RPB3KZ, 0RPB40Z, 0RPB43Z, 0RPB47Z, 0RPB4KZ, 0RQ00ZZ, 0RQ03ZZ, 0RQ04ZZ, 0RQ10ZZ, 0RQ13ZZ, 0RQ14ZZ, 0RQ30ZZ, 0RQ33ZZ, 0RQ34ZZ, 0RQ40ZZ, 0RQ43ZZ, 0RQ44ZZ, 0RQ50ZZ, 0RQ53ZZ, 0RQ54ZZ, 0RQ60ZZ, 0RQ63ZZ, 0RQ64ZZ, 0RQ90ZZ, 0RQ93ZZ, 0RQ94ZZ, 0RQA0ZZ, 0RQA3ZZ, 0RQA4ZZ, 0RQB0ZZ, 0RQB3ZZ, 0RQB4ZZ, 0RQC0ZZ, 0RQC3ZZ, 0RQC4ZZ, 0RQD0ZZ, 0RQD3ZZ, 0RQD4ZZ, 0RR007Z, 0RR00JZ, 0RR00KZ, 0RR107Z, 0RR10JZ, 0RR10KZ, 0RR307Z, 0RR30KZ, 0RR407Z, 0RR40JZ, 0RR40KZ, 0RR507Z, 0RR50KZ, 0RR607Z, 0RR60JZ, 0RR60KZ, 0RR907Z, 0RR90KZ, 0RRA07Z, 0RRA0JZ, 0RRA0KZ, 0RRB07Z, 0RRB0KZ, 0RRC07Z, 0RRC0JZ, 0RRC0KZ, 0RRD07Z, 0RRD0JZ, 0RRD0KZ, 0RS004Z, 0RS00ZZ, 0RS104Z, 0RS10ZZ, 0RS404Z, 0RS40ZZ, 0RS604Z, 0RS60ZZ, 0RSA04Z, 0RSA0ZZ, 0RSC04Z, 0RSC0ZZ, 0RSD04Z, 0RSD0ZZ, 0RTC0ZZ, 0RTD0ZZ, 0RU007Z, 0RU00JZ, 0RU00KZ, 0RU037Z, 0RU03KZ, 0RU047Z, 0RU04KZ, 0RU107Z, 0RU10KZ, 0RU137Z, 0RU13KZ, 0RU147Z, 0RU14KZ, 0RU407Z, 0RU40KZ, 0RU437Z, 0RU43KZ, 0RU447Z, 0RU44KZ, 0RU507Z, 0RU50KZ, 0RU537Z, 0RU53KZ, 0RU547Z, 0RU54KZ, 0RU607Z, 0RU60KZ, 0RU637Z, 0RU63KZ, 0RU647Z, 0RU64KZ, 0RUA07Z, 0RUA0KZ, 0RUA37Z, 0RUA3KZ, 0RUA47Z, 0RUA4KZ, 0RUC07Z, 0RUC0JZ, 0RUC0KZ, 0RUC37Z, 0RUC3JZ, 0RUC3KZ, 0RUC47Z, 0RUC4JZ, 0RUC4KZ, 0RUD07Z, 0RUD0JZ, 0RUD0KZ, 0RUD37Z, 0RUD3JZ, 0RUD3KZ, 0RUD47Z, 0RUD4JZ, 0RUD4KZ, 0RW000Z, 0RW003Z, 0RW004Z, 0RW007Z, 0RW008Z, 0RW00AZ, 0RW00JZ, 0RW00KZ, 0RW030Z, 0RW033Z, 0RW034Z, 0RW037Z, 0RW038Z, 0RW03AZ, 0RW03JZ, 0RW03KZ, 0RW040Z, 0RW043Z, 0RW044Z, 0RW047Z, 0RW048Z, 0RW04AZ, 0RW04JZ, 0RW04KZ, 0RW100Z, 0RW103Z, 0RW104Z, 0RW107Z, 0RW108Z, 0RW10AZ, 0RW10JZ, 0RW10KZ, 0RW130Z, 0RW133Z, 0RW134Z, 0RW137Z, 0RW138Z, 0RW13AZ, 0RW13JZ, 0RW13KZ, 0RW140Z, 0RW143Z, 0RW144Z, 0RW147Z, 0RW148Z,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0RW14AZ, 0RW14JZ, 0RW14KZ, 0RW300Z, 0RW303Z, 0RW307Z, 0RW30KZ, 0RW330Z, 0RW333Z, 0RW337Z, 0RW33KZ, 0RW340Z, 0RW343Z, 0RW347Z, 0RW34KZ, 0RW400Z, 0RW403Z, 0RW404Z, 0RW407Z, 0RW408Z, 0RW40AZ, 0RW40JZ, 0RW40KZ, 0RW430Z, 0RW433Z, 0RW434Z, 0RW437Z, 0RW438Z, 0RW43AZ, 0RW43JZ, 0RW43KZ, 0RW440Z, 0RW443Z, 0RW444Z, 0RW447Z, 0RW448Z, 0RW44AZ, 0RW44JZ, 0RW44KZ, 0RW500Z, 0RW503Z, 0RW507Z, 0RW50KZ, 0RW530Z, 0RW533Z, 0RW537Z, 0RW53KZ, 0RW540Z, 0RW543Z, 0RW547Z, 0RW54KZ, 0RW600Z, 0RW603Z, 0RW604Z, 0RW607Z, 0RW608Z, 0RW60AZ, 0RW60JZ, 0RW60KZ, 0RW630Z, 0RW633Z, 0RW634Z, 0RW637Z, 0RW638Z, 0RW63AZ, 0RW63JZ, 0RW63KZ, 0RW640Z, 0RW643Z, 0RW644Z, 0RW647Z, 0RW648Z, 0RW64AZ, 0RW64JZ, 0RW64KZ, 0RW900Z, 0RW903Z, 0RW907Z, 0RW90KZ, 0RW930Z, 0RW933Z, 0RW937Z, 0RW93KZ, 0RW940Z, 0RW943Z, 0RW947Z, 0RW94KZ, 0RWA00Z, 0RWA03Z, 0RWA04Z, 0RWA07Z, 0RWA08Z, 0RWA0AZ, 0RWA0JZ, 0RWA0KZ, 0RWA30Z, 0RWA33Z, 0RWA34Z, 0RWA37Z, 0RWA38Z, 0RWA3AZ, 0RWA3JZ, 0RWA3KZ, 0RWA40Z, 0RWA43Z, 0RWA44Z, 0RWA47Z, 0RWA48Z, 0RWA4AZ, 0RWA4JZ, 0RWA4KZ, 0RWB00Z, 0RWB03Z, 0RWB07Z, 0RWB0KZ, 0RWB30Z, 0RWB33Z, 0RWB37Z, 0RWB3KZ, 0RWB40Z, 0RWB43Z, 0RWB47Z, 0RWB4KZ, 0RWG0JZ, 0RWG3JZ, 0RWG4JZ, 0RWH0JZ, 0RWH3JZ, 0RWH4JZ, 0RWJ0JZ, 0RWJ3JZ, 0RWJ4JZ, 0RWK0JZ, 0RWK3JZ, 0RWK4JZ, 0RWL0JZ, 0RWL3JZ, 0RWL4JZ, 0RWM0JZ, 0RWM3JZ, 0RWM4JZ, 0RWN0JZ, 0RWN3JZ, 0RWN4JZ, 0RWP0JZ, 0RWP3JZ, 0RWP4JZ, 0RWQ0JZ, 0RWQ3JZ, 0RWQ4JZ, 0RWR0JZ, 0RWR3JZ, 0RWR4JZ, 0RWS0JZ, 0RWS3JZ, 0RWS4JZ, 0RWT0JZ, 0RWT3JZ, 0RWT4JZ, 0RWU0JZ, 0RWU3JZ, 0RWU4JZ, 0RWV0JZ, 0RWV3JZ, 0RWV4JZ, 0RWW0JZ, 0RWW3JZ, 0RWW4JZ, 0RWX0JZ, 0RWX3JZ, 0RWX4JZ, 0S9000Z, 0S900ZZ, 0S9200Z, 0S920ZZ, 0S9300Z, 0S930ZZ, 0S9400Z, 0S940ZZ, 0S9500Z, 0S950ZZ, 0S9600Z, 0S960ZZ, 0S9700Z, 0S970ZZ, 0S9800Z, 0S980ZZ, 0SC00ZZ, 0SC03ZZ, 0SC04ZZ, 0SC20ZZ, 0SC23ZZ, 0SC24ZZ, 0SC30ZZ, 0SC33ZZ, 0SC34ZZ, 0SC40ZZ, 0SC43ZZ, 0SC44ZZ, 0SC50ZZ, 0SC53ZZ, 0SC54ZZ, 0SC60ZZ, 0SC63ZZ, 0SC64ZZ, 0SC70ZZ, 0SC73ZZ, 0SC74ZZ, 0SC80ZZ, 0SC83ZZ, 0SC84ZZ, 0SH004Z, 0SH034Z, 0SH044Z, 0SH304Z, 0SH334Z, 0SH344Z, 0SH504Z, 0SH534Z, 0SH544Z, 0SH604Z, 0SH634Z, 0SH644Z, 0SH704Z, 0SH734Z, 0SH744Z, 0SH804Z, 0SH834Z, 0SH844Z, 0SJ00ZZ, 0SJ20ZZ, 0SJ30ZZ, 0SJ40ZZ, 0SJ50ZZ, 0SJ60ZZ, 0SJ70ZZ, 0SJ80ZZ, 0SP000Z, 0SP003Z, 0SP004Z, 0SP007Z, 0SP00AZ, 0SP00KZ, 0SP034Z, 0SP037Z, 0SP03AZ, 0SP03KZ, 0SP040Z, 0SP043Z, 0SP044Z,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0SP047Z, 0SP04AZ, 0SP04KZ, 0SP200Z, 0SP203Z, 0SP207Z, 0SP20KZ, 0SP237Z, 0SP23KZ, 0SP240Z, 0SP243Z, 0SP247Z, 0SP24KZ, 0SP300Z, 0SP303Z, 0SP304Z, 0SP307Z, 0SP30AZ, 0SP30KZ, 0SP334Z, 0SP337Z, 0SP33AZ, 0SP33KZ, 0SP340Z, 0SP343Z, 0SP344Z, 0SP347Z, 0SP34AZ, 0SP34KZ, 0SP400Z, 0SP403Z, 0SP407Z, 0SP40KZ, 0SP437Z, 0SP43KZ, 0SP440Z, 0SP443Z, 0SP447Z, 0SP44KZ, 0SP500Z, 0SP503Z, 0SP504Z, 0SP507Z, 0SP50KZ, 0SP534Z, 0SP537Z, 0SP53KZ, 0SP540Z, 0SP543Z, 0SP544Z, 0SP547Z, 0SP54KZ, 0SP600Z, 0SP603Z, 0SP604Z, 0SP607Z, 0SP60KZ, 0SP634Z, 0SP637Z, 0SP63KZ, 0SP640Z, 0SP643Z, 0SP644Z, 0SP647Z, 0SP64KZ, 0SP700Z, 0SP703Z, 0SP704Z, 0SP707Z, 0SP70KZ, 0SP734Z, 0SP737Z, 0SP73KZ, 0SP740Z, 0SP743Z, 0SP744Z, 0SP747Z, 0SP74KZ, 0SP800Z, 0SP803Z, 0SP804Z, 0SP807Z, 0SP80KZ, 0SP834Z, 0SP837Z, 0SP83KZ, 0SP840Z, 0SP843Z, 0SP844Z, 0SP847Z, 0SP84KZ, 0SQ00ZZ, 0SQ03ZZ, 0SQ04ZZ, 0SQ20ZZ, 0SQ23ZZ, 0SQ24ZZ, 0SQ30ZZ, 0SQ33ZZ, 0SQ34ZZ, 0SQ40ZZ, 0SQ43ZZ, 0SQ44ZZ, 0SQ50ZZ, 0SQ53ZZ, 0SQ54ZZ, 0SQ60ZZ, 0SQ63ZZ, 0SQ64ZZ, 0SQ70ZZ, 0SQ73ZZ, 0SQ74ZZ, 0SQ80ZZ, 0SQ83ZZ, 0SQ84ZZ, 0SQH0ZZ, 0SQH3ZZ, 0SQH4ZZ, 0SQJ0ZZ, 0SQJ3ZZ, 0SQJ4ZZ, 0SQK0ZZ, 0SQK3ZZ, 0SQK4ZZ, 0SQL0ZZ, 0SQL3ZZ, 0SQL4ZZ, 0SQM0ZZ, 0SQM3ZZ, 0SQM4ZZ, 0SQN0ZZ, 0SQN3ZZ, 0SQN4ZZ, 0SQP0ZZ, 0SQP3ZZ, 0SQP4ZZ, 0SQQ0ZZ, 0SQQ3ZZ, 0SQQ4ZZ, 0SR007Z, 0SR00JZ, 0SR00KZ, 0SR207Z, 0SR20KZ, 0SR307Z, 0SR30JZ, 0SR30KZ, 0SR407Z, 0SR40KZ, 0SR507Z, 0SR50JZ, 0SR50KZ, 0SR607Z, 0SR60JZ, 0SR60KZ, 0SR707Z, 0SR70JZ, 0SR70KZ, 0SR807Z, 0SR80JZ, 0SR80KZ, 0SS004Z, 0SS00ZZ, 0SS304Z, 0SS30ZZ, 0SS504Z, 0SS50ZZ, 0SS604Z, 0SS60ZZ, 0SS704Z, 0SS70ZZ, 0SS804Z, 0SS80ZZ, 0ST50ZZ, 0ST60ZZ, 0ST70ZZ, 0ST80ZZ, 0SU007Z, 0SU00KZ, 0SU037Z, 0SU03KZ, 0SU047Z, 0SU04KZ, 0SU307Z, 0SU30KZ, 0SU337Z, 0SU33KZ, 0SU347Z, 0SU34KZ, 0SU507Z, 0SU50KZ, 0SU537Z, 0SU53KZ, 0SU547Z, 0SU54KZ, 0SU607Z, 0SU60KZ, 0SU637Z, 0SU63KZ, 0SU647Z, 0SU64KZ, 0SU707Z, 0SU70JZ, 0SU70KZ, 0SU737Z, 0SU73JZ, 0SU73KZ, 0SU747Z, 0SU74JZ, 0SU74KZ, 0SU807Z, 0SU80JZ, 0SU80KZ, 0SU837Z, 0SU83JZ, 0SU83KZ, 0SU847Z, 0SU84JZ, 0SU84KZ, 0SU907Z, 0SU909Z, 0SU90JZ, 0SU90KZ, 0SU937Z, 0SU93JZ, 0SU93KZ, 0SU947Z, 0SU94JZ, 0SU94KZ, 0SUA09Z, 0SUB07Z, 0SUB09Z, 0SUB0JZ, 0SUB0KZ, 0SUB37Z, 0SUB3JZ, 0SUB3KZ, 0SUB47Z, 0SUB4JZ, 0SUB4KZ, 0SUC07Z, 0SUC09C, 0SUC09Z, 0SUC0JZ, 0SUC0KZ, 0SUC37Z, 0SUC3JZ, 0SUC3KZ, 0SUC47Z, 0SUC4JZ, 0SUC4KZ, 0SUD07Z, 0SUD09C, 0SUD09Z, 0SUD0JZ, 0SUD0KZ, 0SUD37Z, 0SUD3JZ, 0SUD3KZ, 0SUD47Z, 0SUD4JZ, 0SUD4KZ, 0SUE09Z, 0SUF07Z, 0SUF0JZ,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0SUF0KZ, 0SUF37Z, 0SUF3JZ, 0SUF3KZ, 0SUF47Z, 0SUF4JZ, 0SUF4KZ, 0SUG07Z, 0SUG0JZ, 0SUG0KZ, 0SUG37Z, 0SUG3JZ, 0SUG3KZ, 0SUG47Z, 0SUG4JZ, 0SUG4KZ, 0SUH07Z, 0SUH0JZ, 0SUH0KZ, 0SUH37Z, 0SUH3JZ, 0SUH3KZ, 0SUH47Z, 0SUH4JZ, 0SUH4KZ, 0SUJ07Z, 0SUJ0JZ, 0SUJ0KZ, 0SUJ37Z, 0SUJ3JZ, 0SUJ3KZ, 0SUJ47Z, 0SUJ4JZ, 0SUJ4KZ, 0SUK07Z, 0SUK0JZ, 0SUK0KZ, 0SUK37Z, 0SUK3JZ, 0SUK3KZ, 0SUK47Z, 0SUK4JZ, 0SUK4KZ, 0SUL07Z, 0SUL0JZ, 0SUL0KZ, 0SUL37Z, 0SUL3JZ, 0SUL3KZ, 0SUL47Z, 0SUL4JZ, 0SUL4KZ, 0SUM07Z, 0SUM0JZ, 0SUM0KZ, 0SUM37Z, 0SUM3JZ, 0SUM3KZ, 0SUM47Z, 0SUM4JZ, 0SUM4KZ, 0SUN07Z, 0SUN0JZ, 0SUN0KZ, 0SUN37Z, 0SUN3JZ, 0SUN3KZ, 0SUN47Z, 0SUN4JZ, 0SUN4KZ, 0SUP07Z, 0SUP0JZ, 0SUP0KZ, 0SUP37Z, 0SUP3JZ, 0SUP3KZ, 0SUP47Z, 0SUP4JZ, 0SUP4KZ, 0SUQ07Z, 0SUQ0JZ, 0SUQ0KZ, 0SUQ37Z, 0SUQ3JZ, 0SUQ3KZ, 0SUQ47Z, 0SUQ4JZ, 0SUQ4KZ, 0SUR09Z, 0SUS09Z, 0SUT09Z, 0SUU09Z, 0SUV09Z, 0SUW09Z, 0SW000Z, 0SW003Z, 0SW004Z, 0SW007Z, 0SW008Z, 0SW00AZ, 0SW00JZ, 0SW00KZ, 0SW030Z, 0SW033Z, 0SW034Z, 0SW037Z, 0SW038Z, 0SW03AZ, 0SW03JZ, 0SW03KZ, 0SW040Z, 0SW043Z, 0SW044Z, 0SW047Z, 0SW048Z, 0SW04AZ, 0SW04JZ, 0SW04KZ, 0SW200Z, 0SW203Z, 0SW207Z, 0SW20KZ, 0SW230Z, 0SW233Z, 0SW237Z, 0SW23KZ, 0SW240Z, 0SW243Z, 0SW247Z, 0SW24KZ, 0SW300Z, 0SW303Z, 0SW304Z, 0SW307Z, 0SW308Z, 0SW30AZ, 0SW30JZ, 0SW30KZ, 0SW330Z, 0SW333Z, 0SW334Z, 0SW337Z, 0SW338Z, 0SW33AZ, 0SW33JZ, 0SW33KZ, 0SW340Z, 0SW343Z, 0SW344Z, 0SW347Z, 0SW348Z, 0SW34AZ, 0SW34JZ, 0SW34KZ, 0SW400Z, 0SW403Z, 0SW407Z, 0SW40KZ, 0SW430Z, 0SW433Z, 0SW437Z, 0SW43KZ, 0SW440Z, 0SW443Z, 0SW447Z, 0SW44KZ, 0SW500Z, 0SW503Z, 0SW504Z, 0SW507Z, 0SW508Z, 0SW50JZ, 0SW50KZ, 0SW530Z, 0SW533Z, 0SW534Z, 0SW537Z, 0SW538Z, 0SW53JZ, 0SW53KZ, 0SW540Z, 0SW543Z, 0SW544Z, 0SW547Z, 0SW548Z, 0SW54JZ, 0SW54KZ, 0SW600Z, 0SW603Z, 0SW604Z, 0SW607Z, 0SW608Z, 0SW60JZ, 0SW60KZ, 0SW630Z, 0SW633Z, 0SW634Z, 0SW637Z, 0SW638Z, 0SW63JZ, 0SW63KZ, 0SW640Z, 0SW643Z, 0SW644Z, 0SW647Z, 0SW648Z, 0SW64JZ, 0SW64KZ, 0SW700Z, 0SW703Z, 0SW704Z, 0SW707Z, 0SW708Z, 0SW70JZ, 0SW70KZ, 0SW730Z, 0SW733Z, 0SW734Z, 0SW737Z, 0SW738Z, 0SW73JZ, 0SW73KZ, 0SW740Z, 0SW743Z, 0SW744Z, 0SW747Z, 0SW748Z, 0SW74JZ, 0SW74KZ, 0SW800Z, 0SW803Z, 0SW804Z, 0SW807Z, 0SW808Z, 0SW80JZ, 0SW80KZ, 0SW830Z, 0SW833Z, 0SW834Z, 0SW837Z, 0SW838Z, 0SW83JZ,

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Other musculoskelet sys & conn tiss O.R. proc (cont.)	515 (cont.)	0SW83KZ, 0SW840Z, 0SW843Z, 0SW844Z, 0SW847Z, 0SW848Z, 0SW84JZ, 0SW84KZ, 0SWF0JZ, 0SWF3JZ, 0SWF4JZ, 0SWG0JZ, 0SWG3JZ, 0SWG4JZ, 0SWH0JZ, 0SWH3JZ, 0SWH4JZ, 0SWJ0JZ, 0SWJ3JZ, 0SWJ4JZ, 0SWK0JZ, 0SWK3JZ, 0SWK4JZ, 0SWL0JZ, 0SWL3JZ, 0SWL4JZ, 0SWM0JZ, 0SWM3JZ, 0SWM4JZ, 0SWN0JZ, 0SWN3JZ, 0SWN4JZ, 0SWP0JZ, 0SWP3JZ, 0SWP4JZ, 0SWQ0JZ, 0SWQ3JZ, 0SWQ4JZ, 0W0407Z, 0W040JZ, 0W040KZ, 0W040ZZ, 0W0437Z, 0W043JZ, 0W043KZ, 0W043ZZ, 0W0447Z, 0W044JZ, 0W044KZ, 0W044ZZ, 0W0507Z, 0W050JZ, 0W050KZ, 0W050ZZ, 0W0537Z, 0W053JZ, 0W053KZ, 0W053ZZ, 0W0547Z, 0W054JZ, 0W054KZ, 0W054ZZ, 0WU407Z, 0WU40JZ, 0WU40KZ, 0WU447Z, 0WU44JZ, 0WU44KZ, 0WU507Z, 0WU50JZ, 0WU50KZ, 0WU547Z, 0WU54JZ, 0WU54KZ, 0YM20ZZ, 0YM30ZZ, 0YM40ZZ, 0YM50ZZ, 0YM60ZZ, 0YM90ZZ, 0YMB0ZZ
		516	See MS-DRG 515
		517	See MS-DRG 515
S	Back & Neck Procedures Except Spinal Fusion	518	Include all
		519	Include all
		520	Include all
M	Fractures of femur	533	Include all
		534	Include all
M	Fractures of hip & pelvis	535	Include all
		536	Include all
M	Osteomyelitis	539	Include all
		540	Include all
		541	Include all

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Orthopedics (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Pathological fractures & musculoskelet & conn tiss malig	542	Include diagnoses: M48.40XA, M48.41XA, M48.42XA, M48.43XA, M48.44XA, M48.45XA, M48.46XA, M48.47XA, M48.48XA, M48.50XA, M48.51XA, M48.52XA, M48.53XA, M48.54XA, M48.55XA, M48.56XA, M48.57XA, M48.58XA, M80.00XA, M80.011A, M80.012A, M80.019A, M80.021A, M80.022A, M80.029A, M80.031A, M80.032A, M80.039A, M80.041A, M80.042A, M80.049A, M80.051A, M80.052A, M80.059A, M80.061A, M80.062A, M80.069A, M80.071A, M80.072A, M80.079A, M80.08XA, M80.80XA, M80.811A, M80.812A, M80.819A, M80.821A, M80.822A, M80.829A, M80.831A, M80.832A, M80.839A, M80.841A, M80.842A, M80.849A, M80.851A, M80.852A, M80.859A, M80.861A, M80.862A, M80.869A, M80.871A, M80.872A, M80.879A, M80.88XA, M84.30XA, M84.311A, M84.312A, M84.319A, M84.321A, M84.322A, M84.329A, M84.331A, M84.332A, M84.333A, M84.334A, M84.339A, M84.341A, M84.342A, M84.343A, M84.344A, M84.345A, M84.346A, M84.350A, M84.351A, M84.352A, M84.353A, M84.359A, M84.361A, M84.362A, M84.363A, M84.364A, M84.369A, M84.371A, M84.372A, M84.373A, M84.374A, M84.375A, M84.376A, M84.377A, M84.378A, M84.379A, M84.38XA, M84.40XA, M84.411A, M84.412A, M84.419A, M84.421A, M84.422A, M84.429A, M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.441A, M84.442A, M84.443A, M84.444A, M84.445A, M84.446A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.461A, M84.462A, M84.463A, M84.464A, M84.469A, M84.471A, M84.472A, M84.473A, M84.474A, M84.475A, M84.476A, M84.477A, M84.478A, M84.479A, M84.48XA, M84.50XA, M84.511A, M84.512A, M84.519A, M84.521A, M84.522A, M84.529A, M84.531A, M84.532A, M84.533A, M84.534A, M84.539A, M84.541A, M84.542A, M84.549A, M84.550A, M84.551A, M84.552A, M84.553A, M84.559A, M84.561A, M84.562A, M84.563A, M84.564A, M84.569A, M84.571A, M84.572A, M84.573A, M84.574A, M84.575A, M84.576A, M84.58XA, M84.60XA, M84.611A, M84.612A, M84.619A, M84.621A, M84.622A, M84.629A, M84.631A, M84.632A, M84.633A, M84.634A, M84.639A, M84.641A, M84.642A, M84.649A, M84.650A, M84.651A, M84.652A, M84.653A, M84.659A, M84.661A, M84.662A, M84.663A, M84.664A, M84.669A, M84.671A, M84.672A, M84.673A, M84.674A, M84.675A, M84.676A, M84.68XA, M84.750A, M84.751A, M84.752A, M84.753A, M84.754A, M84.755A, M84.756A, M84.757A, M84.758A, M84.759A
		543	See MS-DRG 542
		544	See MS-DRG 542
S	Limb reattachment, hip & femur proc for multiple significant trauma	956	Include all

*Exclude principle diagnosis of metastatic cancer for all except MS-DRGs 542-544 or DRGs 456-458: C770, C771, C772, C773, C774, C775, C778, C779, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7963, C7970, C7971, C7972, C7981, C7982, C7989, C799, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C800.

Pulmonology & Lung Surgery

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	003	Include all
S	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	004	Include all
S	Lung transplant	007	Include all
S	Major chest procedures	163	Include procedures: 02JA0ZZ, 02JY0ZZ, 0B530ZZ, 0B533ZZ, 0B537ZZ, 0B538ZZ, 0B540ZZ, 0B543ZZ, 0B547ZZ, 0B548ZZ, 0B550ZZ, 0B553ZZ, 0B557ZZ, 0B558ZZ, 0B560ZZ, 0B563ZZ, 0B567ZZ, 0B568ZZ, 0B570ZZ, 0B573ZZ, 0B577ZZ, 0B578ZZ, 0B580ZZ, 0B583ZZ, 0B587ZZ, 0B588ZZ, 0B590ZZ, 0B593ZZ, 0B597ZZ, 0B598ZZ, 0B5B0ZZ, 0B5B3ZZ, 0B5B7ZZ, 0B5B8ZZ, 0B5C0ZZ, 0B5C4ZZ, 0B5C7ZZ, 0B5D0ZZ, 0B5D4ZZ, 0B5D7ZZ, 0B5F0ZZ, 0B5F4ZZ, 0B5F7ZZ, 0B5G0ZZ, 0B5G4ZZ, 0B5G7ZZ, 0B5H0ZZ, 0B5H3ZZ, 0B5H7ZZ, 0B5J0ZZ, 0B5J4ZZ, 0B5J7ZZ, 0B5K0ZZ, 0B5K4ZZ, 0B5K7ZZ, 0B5L0ZZ, 0B5L4ZZ, 0B5L7ZZ, 0B5M0ZZ, 0B5M4ZZ, 0B5M7ZZ, 0B5N0ZZ, 0B5N3ZZ, 0B5N4ZZ, 0B5P0ZZ, 0B5P3ZZ, 0B5P4ZZ, 0B5T0ZZ, 0B5T3ZZ, 0B5T4ZZ, 0B9300Z, 0B930ZX, 0B930ZZ, 0B9330Z, 0B933ZZ, 0B9340Z, 0B934ZZ, 0B9370Z, 0B937ZZ, 0B9380Z, 0B938ZZ, 0B9400Z, 0B940ZX, 0B940ZZ, 0B9430Z, 0B943ZZ, 0B9440Z, 0B944ZZ, 0B9480Z, 0B948ZZ, 0B9500Z, 0B950ZX, 0B950ZZ, 0B9530Z, 0B953ZZ, 0B9540Z, 0B954ZZ, 0B9600Z, 0B960ZX, 0B960ZZ, 0B9630Z, 0B963ZZ, 0B9640Z, 0B964ZZ, 0B9700Z, 0B970ZX, 0B970ZZ, 0B9730Z, 0B973ZZ, 0B9740Z, 0B974ZZ, 0B9800Z, 0B980ZX, 0B980ZZ, 0B9830Z, 0B983ZZ, 0B9840Z, 0B984ZZ, 0B9900Z, 0B990ZX, 0B990ZZ, 0B9930Z, 0B993ZZ, 0B9940Z, 0B994ZZ, 0B9B00Z, 0B9B0ZX, 0B9B0ZZ, 0B9B30Z, 0B9B3ZZ, 0B9B40Z, 0B9B4ZZ, 0B9C00Z, 0B9C0ZX, 0B9C0ZZ, 0B9D00Z, 0B9D0ZX, 0B9D0ZZ, 0B9F00Z, 0B9F0ZX, 0B9F0ZZ, 0B9G00Z, 0B9G0ZX, 0B9G0ZZ, 0B9H00Z, 0B9H0ZX, 0B9H0ZZ, 0B9J00Z, 0B9J0ZX, 0B9J0ZZ, 0B9K00Z, 0B9K0ZX, 0B9K0ZZ, 0B9L00Z, 0B9L0ZX, 0B9L0ZZ, 0B9M00Z, 0B9M0ZX, 0B9M0ZZ, 0B9T00Z, 0B9T0ZX, 0B9T0ZZ, 0BB30ZX, 0BB30ZZ, 0BB33ZZ, 0BB37ZZ, 0BB40ZX, 0BB40ZZ, 0BB43ZZ, 0BB47ZZ, 0BB50ZX, 0BB50ZZ, 0BB53ZZ, 0BB57ZZ, 0BB60ZX, 0BB60ZZ, 0BB63ZZ, 0BB67ZZ, 0BB70ZX, 0BB70ZZ, 0BB73ZZ, 0BB77ZZ, 0BB80ZX, 0BB80ZZ, 0BB83ZZ, 0BB87ZZ, 0BB90ZX, 0BB90ZZ, 0BB93ZZ, 0BB97ZZ, 0BBB0ZX, 0BBB0ZZ, 0BBB3ZZ, 0BBB7ZZ, 0BBC0ZX, 0BBC0ZZ, 0BBC3ZZ, 0BBC4ZZ, 0BBC7ZZ, 0BBD0ZX, 0BBD0ZZ, 0BBD3ZZ, 0BBD4ZZ, 0BBD7ZZ, 0BBF0ZX, 0BBF0ZZ, 0BBF3ZZ, 0BBF4ZZ, 0BBF7ZZ, 0BBG0ZX, 0BBG0ZZ, 0BBG3ZZ, 0BBG4ZZ,

Pulmonology & Lung Surgery (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Major chest procedures (cont.)	163 (cont.)	0BBG7ZZ, 0BBH0ZX, 0BBH0ZZ, 0BBH3ZZ, 0BBH4ZZ, 0BBH7ZZ, 0BBJ0ZX, 0BBJ0ZZ, 0BBJ3ZZ, 0BBJ4ZZ, 0BBJ7ZZ, 0BBK0ZX, 0BBK0ZZ, 0BBK3ZZ, 0BBK4ZZ, 0BBK7ZZ, 0BBL0ZX, 0BBL0ZZ, 0BBL3ZZ, 0BBL4ZZ, 0BBL7ZZ, 0BBM0ZX, 0BBM0ZZ, 0BBM3ZZ, 0BBM7ZZ, 0BBN0ZZ, 0BBN3ZZ, 0BBN4ZZ, 0BBN8ZZ, 0BBP0ZZ, 0BBP3ZZ, 0BBP4ZZ, 0BBP8ZZ, 0BBT0ZX, 0BBT0ZZ, 0BBT3ZX, 0BBT3ZZ, 0BBT4ZX, 0BBT4ZZ, 0BC30ZZ, 0BC33ZZ, 0BC34ZZ, 0BC40ZZ, 0BC43ZZ, 0BC44ZZ, 0BC50ZZ, 0BC53ZZ, 0BC54ZZ, 0BC60ZZ, 0BC63ZZ, 0BC64ZZ, 0BC70ZZ, 0BC73ZZ, 0BC74ZZ, 0BC80ZZ, 0BC83ZZ, 0BC84ZZ, 0BC90ZZ, 0BC93ZZ, 0BC94ZZ, 0BCB0ZZ, 0BCB3ZZ, 0BCB4ZZ, 0BCC0ZZ, 0BCC3ZZ, 0BCC4ZZ, 0BCC7ZZ, 0BCD0ZZ, 0BCD3ZZ, 0BCD4ZZ, 0BCD7ZZ, 0BCD8ZZ, 0BCF0ZZ, 0BCF3ZZ, 0BCF4ZZ, 0BCF7ZZ, 0BCF8ZZ, 0BCG0ZZ, 0BCG3ZZ, 0BCG4ZZ, 0BCG7ZZ, 0BCG8ZZ, 0BCH0ZZ, 0BCH3ZZ, 0BCH4ZZ, 0BCH7ZZ, 0BCH8ZZ, 0BCJ0ZZ, 0BCJ3ZZ, 0BCJ4ZZ, 0BCJ7ZZ, 0BCJ8ZZ, 0BCK0ZZ, 0BCK3ZZ, 0BCK4ZZ, 0BCK7ZZ, 0BCK8ZZ, 0BCL0ZZ, 0BCL3ZZ, 0BCL4ZZ, 0BCL7ZZ, 0BCL8ZZ, 0BCM0ZZ, 0BCM3ZZ, 0BCM4ZZ, 0BCM7ZZ, 0BCM8ZZ, 0BCT0ZZ, 0BCT3ZZ, 0BCT4ZZ, 0BDN0ZX, 0BDN0ZZ, 0BDN3ZX, 0BDN3ZZ, 0BDN4ZX, 0BDN4ZZ, 0BDP0ZX, 0BDP0ZZ, 0BDP3ZX, 0BDP3ZZ, 0BDP4ZX, 0BDP4ZZ, 0BF10ZZ, 0BF13ZZ, 0BF14ZZ, 0BF17ZZ, 0BF18ZZ, 0BF20ZZ, 0BF23ZZ, 0BF24ZZ, 0BF27ZZ, 0BF28ZZ, 0BF30ZZ, 0BF33ZZ, 0BF34ZZ, 0BF40ZZ, 0BF43ZZ, 0BF44ZZ, 0BF50ZZ, 0BF53ZZ, 0BF54ZZ, 0BF60ZZ, 0BF63ZZ, 0BF64ZZ, 0BF70ZZ, 0BF73ZZ, 0BF74ZZ, 0BF80ZZ, 0BF83ZZ, 0BF84ZZ, 0BF90ZZ, 0BF93ZZ, 0BF94ZZ, 0BFB0ZZ, 0BFB3ZZ, 0BFB4ZZ, 0BH002Z, 0BH003Z, 0BH00DZ, 0BH00YZ, 0BH032Z, 0BH033Z, 0BH03DZ, 0BH042Z, 0BH043Z, 0BH04DZ, 0BH04YZ, 0BH30GZ, 0BH33GZ, 0BH34GZ, 0BH37GZ, 0BH40GZ, 0BH43GZ, 0BH44GZ, 0BH47GZ, 0BH50GZ, 0BH53GZ, 0BH54GZ, 0BH57GZ, 0BH60GZ, 0BH63GZ, 0BH64GZ, 0BH67GZ, 0BH70GZ, 0BH73GZ, 0BH74GZ, 0BH77GZ, 0BH80GZ, 0BH83GZ, 0BH84GZ, 0BH87GZ, 0BH90GZ, 0BH93GZ, 0BH94GZ, 0BH97GZ, 0BHB0GZ, 0BHB3GZ, 0BHB4GZ, 0BHB7GZ, 0BHK02Z, 0BHK03Z, 0BHK0YZ, 0BHK32Z, 0BHK33Z, 0BHK42Z, 0BHK43Z, 0BHK4YZ, 0BHL02Z, 0BHL03Z, 0BHL0YZ, 0BHL32Z, 0BHL33Z, 0BHL42Z, 0BHL43Z, 0BHL4YZ, 0BHT02Z, 0BHT0MZ, 0BHT0YZ, 0BHT32Z, 0BHT3MZ, 0BHT3YZ, 0BHT42Z, 0BHT4MZ, 0BHT4YZ, 0BHT7YZ, 0BL30CZ, 0BL30DZ, 0BL30ZZ, 0BL33CZ, 0BL33DZ, 0BL33ZZ, 0BL34CZ, 0BL34DZ, 0BL34ZZ, 0BL37DZ, 0BL37ZZ, 0BL38DZ, 0BL38ZZ, 0BL40CZ, 0BL40DZ, 0BL40ZZ, 0BL43CZ, 0BL43DZ, 0BL43ZZ, 0BL44CZ, 0BL44DZ, 0BL44ZZ, 0BL47DZ, 0BL47ZZ, 0BL48DZ, 0BL48ZZ, 0BL50CZ, 0BL50DZ, 0BL50ZZ, 0BL53CZ, 0BL53DZ, 0BL53ZZ, 0BL54CZ, 0BL54DZ, 0BL54ZZ, 0BL57DZ, 0BL57ZZ, 0BL58DZ, 0BL58ZZ, 0BL60CZ, 0BL60DZ, 0BL60ZZ, 0BL63CZ, 0BL63DZ, 0BL63ZZ, 0BL64CZ, 0BL64DZ, 0BL64ZZ, 0BL67DZ, 0BL67ZZ, 0BL68DZ, 0BL68ZZ, 0BL70CZ, 0BL70DZ, 0BL70ZZ,

Pulmonology & Lung Surgery (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Major chest procedures (cont.)	163 (cont.)	0BL73CZ, 0BL73DZ, 0BL73ZZ, 0BL74CZ, 0BL74DZ, 0BL74ZZ, 0BL77DZ, 0BL77ZZ, 0BL78DZ, 0BL78ZZ, 0BL80CZ, 0BL80DZ, 0BL80ZZ, 0BL83CZ, 0BL83DZ, 0BL83ZZ, 0BL84CZ, 0BL84DZ, 0BL84ZZ, 0BL87DZ, 0BL87ZZ, 0BL88DZ, 0BL88ZZ, 0BL90CZ, 0BL90DZ, 0BL90ZZ, 0BL93CZ, 0BL93DZ, 0BL93ZZ, 0BL94CZ, 0BL94DZ, 0BL94ZZ, 0BL97DZ, 0BL97ZZ, 0BL98DZ, 0BL98ZZ, 0BLB0CZ, 0BLB0DZ, 0BLB0ZZ, 0BLB3CZ, 0BLB3DZ, 0BLB3ZZ, 0BLB4CZ, 0BLB4DZ, 0BLB4ZZ, 0BLB7DZ, 0BLB7ZZ, 0BLB8DZ, 0BLB8ZZ, 0BM10ZZ, 0BM20ZZ, 0BM30ZZ, 0BM40ZZ, 0BM50ZZ, 0BM60ZZ, 0BM70ZZ, 0BM80ZZ, 0BM90ZZ, 0BMB0ZZ, 0BMC0ZZ, 0BMD0ZZ, 0BMF0ZZ, 0BMG0ZZ, 0BMH0ZZ, 0BMJ0ZZ, 0BMK0ZZ, 0BML0ZZ,0BMT0ZZ, 0BN30ZZ, 0BN33ZZ, 0BN34ZZ, 0BN37ZZ, 0BN38ZZ, 0BN40ZZ, 0BN43ZZ, 0BN44ZZ, 0BN47ZZ, 0BN48ZZ, 0BN50ZZ, 0BN53ZZ, 0BN54ZZ, 0BN57ZZ, 0BN58ZZ, 0BN60ZZ, 0BN63ZZ, 0BN64ZZ, 0BN67ZZ, 0BN68ZZ, 0BN70ZZ, 0BN73ZZ, 0BN74ZZ, 0BN77ZZ, 0BN78ZZ, 0BN80ZZ, 0BN83ZZ, 0BN84ZZ, 0BN87ZZ, 0BN88ZZ, 0BN90ZZ, 0BN93ZZ, 0BN94ZZ, 0BN97ZZ, 0BN98ZZ, 0BNB0ZZ, 0BNB3ZZ, 0BNB4ZZ, 0BNB7ZZ, 0BNB8ZZ, 0BNC0ZZ, 0BNC3ZZ, 0BNC4ZZ, 0BNC7ZZ, 0BNC8ZZ, 0BND0ZZ, 0BND3ZZ, 0BND4ZZ, 0BND7ZZ, 0BND8ZZ, 0BNF0ZZ, 0BNF3ZZ, 0BNF4ZZ, 0BNF7ZZ, 0BNF8ZZ, 0BNG0ZZ, 0BNG3ZZ, 0BNG4ZZ, 0BNG7ZZ, 0BNG8ZZ, 0BNH0ZZ, 0BNH3ZZ, 0BNH4ZZ, 0BNH7ZZ, 0BNH8ZZ, 0BNJ0ZZ, 0BNJ3ZZ, 0BNJ4ZZ, 0BNJ7ZZ, 0BNJ8ZZ, 0BNK0ZZ, 0BNK3ZZ, 0BNK4ZZ, 0BNK7ZZ, 0BNK8ZZ, 0BNL0ZZ, 0BNL3ZZ, 0BNL4ZZ, 0BNL7ZZ, 0BNL8ZZ, 0BNM0ZZ, 0BNM3ZZ, 0BNM4ZZ, 0BNM7ZZ, 0BNM8ZZ, 0BNT0ZZ, 0BNT3ZZ, 0BNT4ZZ, 0BP000Z, 0BP001Z, 0BP002Z, 0BP00CZ, 0BP00DZ, 0BP00JZ, 0BP00KZ, 0BP00YZ, 0BP030Z, 0BP031Z, 0BP032Z, 0BP03CZ, 0BP03DZ, 0BP03JZ, 0BP03KZ, 0BP040Z, 0BP041Z, 0BP042Z, 0BP04CZ, 0BP04DZ, 0BP04JZ, 0BP04KZ, 0BP071Z, 0BP081Z, 0BPK00Z, 0BPK01Z, 0BPK02Z, 0BPK03Z, 0BPK0YZ, 0BPK30Z, 0BPK31Z, 0BPK32Z, 0BPK33Z, 0BPK40Z, 0BPK41Z, 0BPK42Z, 0BPK43Z, 0BPK4YZ, 0BPK71Z, 0BPK81Z, 0BPL00Z, 0BPL01Z, 0BPL02Z, 0BPL03Z, 0BPL0YZ, 0BPL30Z, 0BPL31Z, 0BPL32Z, 0BPL33Z, 0BPL40Z, 0BPL41Z, 0BPL42Z, 0BPL43Z, 0BPL4YZ, 0BPL71Z, 0BPL81Z, 0BPT00Z, 0BPT02Z, 0BPT07Z, 0BPT0JZ, 0BPT0KZ, 0BPT0MZ, 0BPT0YZ, 0BPT30Z, 0BPT32Z, 0BPT37Z, 0BPT3JZ, 0BPT3KZ, 0BPT3MZ, 0BPT40Z, 0BPT42Z, 0BPT47Z, 0BPT4JZ, 0BPT4KZ, 0BPT4MZ, 0BPT4YZ, 0BPT77Z, 0BPT7JZ, 0BPT7KZ, 0BPT7MZ, 0BPT87Z, 0BPT8JZ, 0BPT8KZ, 0BPT8MZ, 0BQ10ZZ, 0BQ13ZZ, 0BQ14ZZ, 0BQ17ZZ, 0BQ18ZZ, 0BQ20ZZ, 0BQ23ZZ, 0BQ24ZZ, 0BQ27ZZ, 0BQ28ZZ, 0BQ30ZZ, 0BQ33ZZ, 0BQ34ZZ, 0BQ37ZZ, 0BQ38ZZ, 0BQ40ZZ, 0BQ43ZZ, 0BQ44ZZ, 0BQ47ZZ, 0BQ48ZZ, 0BQ50ZZ, 0BQ53ZZ, 0BQ54ZZ, 0BQ57ZZ, 0BQ58ZZ, 0BQ60ZZ, 0BQ63ZZ, 0BQ64ZZ, 0BQ67ZZ, 0BQ68ZZ, 0BQ70ZZ, 0BQ73ZZ, 0BQ74ZZ, 0BQ77ZZ, 0BQ78ZZ, 0BQ80ZZ, 0BQ83ZZ, 0BQ84ZZ, 0BQ87ZZ, 0BQ88ZZ, 0BQ90ZZ, 0BQ93ZZ, 0BQ94ZZ, 0BQ97ZZ,

Pulmonology & Lung Surgery (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Major chest procedures (cont.)	163 (cont.)	0BQ98ZZ, 0BQB0ZZ, 0BQB3ZZ, 0BQB4ZZ, 0BQB7ZZ, 0BQB8ZZ, 0BQC0ZZ, 0BQC3ZZ, 0BQC4ZZ, 0BQC7ZZ, 0BQC8ZZ, 0BQD0ZZ, 0BQD3ZZ, 0BQD4ZZ, 0BQD7ZZ, 0BQD8ZZ, 0BQF0ZZ, 0BQF3ZZ, 0BQF4ZZ, 0BQF7ZZ, 0BQF8ZZ, 0BQG0ZZ, 0BQG3ZZ, 0BQG4ZZ, 0BQG7ZZ, 0BQG8ZZ, 0BQH0ZZ, 0BQH3ZZ, 0BQH4ZZ, 0BQH7ZZ, 0BQH8ZZ, 0BQJ0ZZ, 0BQJ3ZZ, 0BQJ4ZZ, 0BQJ7ZZ, 0BQJ8ZZ, 0BQK0ZZ, 0BQK3ZZ, 0BQK4ZZ, 0BQK7ZZ, 0BQK8ZZ, 0BQL0ZZ, 0BQL3ZZ, 0BQL4ZZ, 0BQL7ZZ, 0BQL8ZZ, 0BQM0ZZ, 0BQM3ZZ, 0BQM4ZZ, 0BQM7ZZ, 0BQM8ZZ, 0BQN0ZZ, 0BQN3ZZ, 0BQN4ZZ, 0BQP0ZZ, 0BQP3ZZ, 0BQP4ZZ, 0BQT0ZZ, 0BQT3ZZ, 0BQT4ZZ, 0BR107Z, 0BR10JZ, 0BR10KZ, 0BR147Z, 0BR14JZ, 0BR14KZ, 0BR207Z, 0BR20JZ, 0BR20KZ, 0BR247Z, 0BR24JZ, 0BR24KZ, 0BR307Z, 0BR30JZ, 0BR30KZ, 0BR347Z, 0BR34JZ, 0BR34KZ, 0BR407Z, 0BR40JZ, 0BR40KZ, 0BR447Z, 0BR44JZ, 0BR44KZ, 0BR507Z, 0BR50JZ, 0BR50KZ, 0BR547Z, 0BR54JZ, 0BR54KZ, 0BR607Z, 0BR60JZ, 0BR60KZ, 0BR647Z, 0BR64JZ, 0BR64KZ, 0BR707Z, 0BR70JZ, 0BR70KZ, 0BR747Z, 0BR74JZ, 0BR74KZ, 0BR807Z, 0BR80JZ, 0BR80KZ, 0BR847Z, 0BR84JZ, 0BR84KZ, 0BR907Z, 0BR90JZ, 0BR90KZ, 0BR947Z, 0BR94JZ, 0BR94KZ, 0BRB07Z, 0BRB0JZ, 0BRB0KZ, 0BRB47Z, 0BRB4JZ, 0BRB4KZ, 0BS10ZZ, 0BS20ZZ, 0BS30ZZ, 0BS40ZZ, 0BS50ZZ, 0BS60ZZ, 0BS70ZZ, 0BS80ZZ, 0BS90ZZ, 0BSB0ZZ, 0BSC0ZZ, 0BSD0ZZ, 0BSF0ZZ, 0BSG0ZZ, 0BSH0ZZ, 0BSJ0ZZ, 0BSK0ZZ, 0BSL0ZZ, 0BST0ZZ, 0BT10ZZ, 0BT14ZZ, 0BT20ZZ, 0BT24ZZ, 0BT30ZZ, 0BT34ZZ, 0BT40ZZ, 0BT44ZZ, 0BT50ZZ, 0BT54ZZ, 0BT60ZZ, 0BT64ZZ, 0BT70ZZ, 0BT74ZZ, 0BT80ZZ, 0BT84ZZ, 0BT90ZZ, 0BT94ZZ, 0BTB0ZZ, 0BTB4ZZ, 0BTC0ZZ, 0BTC4ZZ, 0BTD0ZZ, 0BTD4ZZ, 0BTF0ZZ, 0BTF4ZZ, 0BTG0ZZ, 0BTG4ZZ, 0BTH0ZZ, 0BTH4ZZ, 0BTJ0ZZ, 0BTJ4ZZ, 0BTK0ZZ, 0BTK4ZZ, 0BTL0ZZ, 0BTL4ZZ, 0BTM0ZZ, 0BTM4ZZ, 0BU107Z, 0BU10JZ, 0BU10KZ, 0BU147Z, 0BU14JZ, 0BU14KZ, 0BU187Z, 0BU18JZ, 0BU18KZ, 0BU207Z, 0BU20JZ, 0BU20KZ, 0BU247Z, 0BU24JZ, 0BU24KZ, 0BU287Z, 0BU28JZ, 0BU28KZ, 0BU307Z, 0BU30JZ, 0BU30KZ, 0BU347Z, 0BU34JZ, 0BU34KZ, 0BU387Z, 0BU38JZ, 0BU38KZ, 0BU407Z, 0BU40JZ, 0BU40KZ, 0BU447Z, 0BU44JZ, 0BU44KZ, 0BU487Z, 0BU48JZ, 0BU48KZ, 0BU507Z, 0BU50JZ, 0BU50KZ, 0BU547Z, 0BU54JZ, 0BU54KZ, 0BU587Z, 0BU58JZ, 0BU58KZ, 0BU607Z, 0BU60JZ, 0BU60KZ, 0BU647Z, 0BU64JZ, 0BU64KZ, 0BU687Z, 0BU68JZ, 0BU68KZ, 0BU707Z, 0BU70JZ, 0BU70KZ, 0BU747Z, 0BU74JZ, 0BU74KZ, 0BU787Z, 0BU78JZ, 0BU78KZ, 0BU807Z, 0BU80JZ, 0BU80KZ, 0BU847Z, 0BU84JZ, 0BU84KZ, 0BU887Z, 0BU88JZ, 0BU88KZ, 0BU907Z, 0BU90JZ, 0BU90KZ, 0BU947Z, 0BU94JZ, 0BU94KZ, 0BU987Z, 0BU98JZ, 0BU98KZ, 0BUB07Z, 0BUB0JZ, 0BUB0KZ, 0BUB47Z, 0BUB4JZ, 0BUB4KZ, 0BUB87Z, 0BUB8JZ, 0BUB8KZ, 0BV10CZ, 0BV10DZ, 0BV10ZZ, 0BV13CZ, 0BV13DZ, 0BV13ZZ, 0BV14CZ, 0BV14DZ, 0BV14ZZ, 0BV17DZ, 0BV17ZZ, 0BV18DZ, 0BV18ZZ, 0BV20CZ, 0BV20DZ, 0BV20ZZ, 0BV23CZ, 0BV23DZ, 0BV23ZZ, 0BV24CZ, 0BV24DZ, 0BV24ZZ, 0BV27DZ, 0BV27ZZ,

Pulmonology & Lung Surgery (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Major chest procedures (cont.)	163 (cont.)	0BV28DZ, 0BV28ZZ, 0BV30CZ, 0BV30DZ, 0BV30ZZ, 0BV33CZ, 0BV33DZ, 0BV33ZZ, 0BV34CZ, 0BV34DZ, 0BV34ZZ, 0BV37DZ, 0BV37ZZ, 0BV38DZ, 0BV38ZZ, 0BV40CZ, 0BV40DZ, 0BV40ZZ, 0BV43CZ, 0BV43DZ, 0BV43ZZ, 0BV44CZ, 0BV44DZ, 0BV44ZZ, 0BV47DZ, 0BV47ZZ, 0BV48DZ, 0BV48ZZ, 0BV50CZ, 0BV50DZ, 0BV50ZZ, 0BV53CZ, 0BV53DZ, 0BV53ZZ, 0BV54CZ, 0BV54DZ, 0BV54ZZ, 0BV57DZ, 0BV57ZZ, 0BV58DZ, 0BV58ZZ, 0BV60CZ, 0BV60DZ, 0BV60ZZ, 0BV63CZ, 0BV63DZ, 0BV63ZZ, 0BV64CZ, 0BV64DZ, 0BV64ZZ, 0BV67DZ, 0BV67ZZ, 0BV68DZ, 0BV68ZZ, 0BV70CZ, 0BV70DZ, 0BV70ZZ, 0BV73CZ, 0BV73DZ, 0BV73ZZ, 0BV74CZ, 0BV74DZ, 0BV74ZZ, 0BV77DZ, 0BV77ZZ, 0BV78DZ, 0BV78ZZ, 0BV80CZ, 0BV80DZ, 0BV80ZZ, 0BV83CZ, 0BV83DZ, 0BV83ZZ, 0BV84CZ, 0BV84DZ, 0BV84ZZ, 0BV87DZ, 0BV87ZZ, 0BV88DZ, 0BV88ZZ, 0BV90CZ, 0BV90DZ, 0BV90ZZ, 0BV93CZ, 0BV93DZ, 0BV93ZZ, 0BV94CZ, 0BV94DZ, 0BV94ZZ, 0BV97DZ, 0BV97ZZ, 0BV98DZ, 0BV98ZZ, 0BVB0CZ, 0BVB0DZ, 0BVB0ZZ, 0BVB3CZ, 0BVB3DZ, 0BVB3ZZ, 0BVB4CZ, 0BVB4DZ, 0BVB4ZZ, 0BVB7DZ, 0BVB7ZZ, 0BVB8DZ, 0BVB8ZZ, 0BW000Z, 0BW002Z, 0BW00CZ, 0BW00DZ, 0BW00JZ, 0BW00KZ, 0BW00YZ, 0BW030Z, 0BW032Z, 0BW03CZ, 0BW03DZ, 0BW03JZ, 0BW03KZ, 0BW040Z, 0BW042Z, 0BW04CZ, 0BW04DZ, 0BW04JZ, 0BW04KZ, 0BW070Z, 0BW080Z, 0BWK00Z, 0BWK02Z, 0BWK03Z, 0BWK0YZ, 0BWK30Z, 0BWK32Z, 0BWK33Z, 0BWK40Z, 0BWK42Z, 0BWK43Z, 0BWK4YZ, 0BWK8YZ, 0BWL00Z, 0BWL02Z, 0BWL03Z, 0BWL0YZ, 0BWL30Z, 0BWL32Z, 0BWL33Z, 0BWL40Z, 0BWL42Z, 0BWL43Z, 0BWL4YZ, 0BWL8YZ, 0BWT00Z, 0BWT02Z, 0BWT07Z, 0BWT0JZ, 0BWT0KZ, 0BWT0MZ, 0BWT0YZ, 0BWT30Z, 0BWT32Z, 0BWT37Z, 0BWT3JZ, 0BWT3KZ, 0BWT3MZ, 0BWT40Z, 0BWT42Z, 0BWT47Z, 0BWT4JZ, 0BWT4KZ, 0BWT4MZ, 0BWT4YZ, 0BWT70Z, 0BWT72Z, 0BWT77Z, 0BWT7JZ, 0BWT7KZ, 0BWT7MZ, 0BWT80Z, 0BWT82Z, 0BWT87Z, 0BWT8JZ, 0BWT8KZ, 0BWT8MZ, 0DQ50ZZ, 0DQ53ZZ, 0DQ54ZZ, 0DQ57ZZ, 0DQ58ZZ, 0WJ90ZZ, 0WJB0ZZ, 0WJC0ZZ, 0WJQ0ZZ, 0WU807Z, 0WU80JZ, 0WU80KZ, 0WU847Z, 0WU84JZ, 0WU84KZ
		164	See MS-DRG 163
		165	See MS-DRG 163
S	Other resp system O.R. procedures	166	Include all
		167	Include all
		168	Include all
M	Pulmonary embolism	175	Include all
		176	Include all
M	Respiratory infections & inflammations	177	Exclude diagnoses: R76.11, R76.12
		178	See MS-DRG 177
		179	See MS-DRG 177

Pulmonology & Lung Surgery (cont.)

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Respiratory neoplasms	180	Exclude diagnoses: D14.2, D14.30, D14.31, D14.32, D14.4, D15.2, D15.7, D15.9, D16.7, D19.0, D3A.090
		181	See MS-DRG 180
		182	See MS-DRG 180
M	Major chest trauma	183	Include all
		184	Include all
		185	Include all
M	Pleural effusion	186	Include all
		187	Include all
M	Pulmonary edema & respiratory failure	189	Include all
M	Chronic obstructive pulmonary disease	190	Include all
		191	Include all
		192	Include all
M	Simple pneumonia & pleurisy	193	Include all
		194	Include all
M	Interstitial lung disease	196	Include all
		197	Include all
		198	Include all
M	Pneumothorax	199	Exclude diagnoses: J95.811
		200	See MS-DRG 199
M	Bronchitis & asthma	202	Include all
M	Respiratory system diagnosis w ventilator support	207	Include all
		208	Include all
M	Septicemia or severe sepsis w MV 96+ hours	870	Include all
		871	Include all
		872	Include all

Urology*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Major bladder procedures	653	Include all
		654	Include all
		655	Include all
S	Kidney & ureter procedures for neoplasm	656	Include procedures: 0T1307B, 0T130JB, 0T130KB, 0T130ZB, 0T1347B, 0T134JB, 0T134KB, 0T134ZB, 0T1407B, 0T140JB, 0T140KB, 0T140ZB, 0T1447B, 0T144JB, 0T144KB, 0T144ZB, 0T16076, 0T16077, 0T16078, 0T16079, 0T1607A, 0T1607B, 0T1607C, 0T1607D, 0T160J6, 0T160J7, 0T160J8, 0T160J9, 0T160JA, 0T160JB, 0T160JC, 0T160JD, 0T160K6, 0T160K7, 0T160K8, 0T160K9, 0T160KA, 0T160KB, 0T160KC, 0T160KD, 0T160Z6, 0T160Z7, 0T160Z8, 0T160Z9, 0T160ZA, 0T160ZB, 0T160ZC, 0T160ZD, 0T163JD, 0T16476, 0T16477, 0T16478, 0T16479, 0T1647A, 0T1647B, 0T1647C, 0T1647D, 0T164J6, 0T164J7, 0T164J8, 0T164J9, 0T164JA, 0T164JB, 0T164JC, 0T164JD, 0T164K6, 0T164K7, 0T164K8, 0T164K9, 0T164KA, 0T164KB, 0T164KC, 0T164KD, 0T164Z6, 0T164Z7, 0T164Z8,

*Exclude principal diagnosis: T8351 (catheter-associated urinary tract infections)

Urology (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Kidney & ureter procedures for neoplasm (cont.)	656 (cont.)	0T164Z9, 0T164ZA, 0T164ZB, 0T164ZC, 0T164ZD, 0T17076, 0T17077, 0T17078, 0T17079, 0T1707A, 0T1707B, 0T1707C, 0T1707D, 0T170J6, 0T170J7, 0T170J8, 0T170J9, 0T170JA, 0T170JB, 0T170JC, 0T170JD, 0T170K6, 0T170K7, 0T170K8, 0T170K9, 0T170KA, 0T170KB, 0T170KC, 0T170KD, 0T170Z6, 0T170Z7, 0T170Z8, 0T170Z9, 0T170ZA, 0T170ZB, 0T170ZC, 0T170ZD, 0T173JD, 0T17476, 0T17477, 0T17478, 0T17479, 0T1747A, 0T1747B, 0T1747C, 0T1747D, 0T174J6, 0T174J7, 0T174J8, 0T174J9, 0T174JA, 0T174JB, 0T174JC, 0T174JD, 0T174K6, 0T174K7, 0T174K8, 0T174K9, 0T174KA, 0T174KB, 0T174KC, 0T174KD, 0T174Z6, 0T174Z7, 0T174Z8, 0T174Z9, 0T174ZA, 0T174ZB, 0T174ZC, 0T174ZD, 0T18076, 0T18077, 0T18078, 0T18079, 0T1807A, 0T1807B, 0T1807C, 0T1807D, 0T180J6, 0T180J7, 0T180J8, 0T180J9, 0T180JA, 0T180JB, 0T180JC, 0T180JD, 0T180K6, 0T180K7, 0T180K8, 0T180K9, 0T180KA, 0T180KB, 0T180KC, 0T180KD, 0T180Z6, 0T180Z7, 0T180Z8, 0T180Z9, 0T180ZA, 0T180ZB, 0T180ZC, 0T180ZD, 0T183JD, 0T18476, 0T18477, 0T18478, 0T18479, 0T1847A, 0T1847B, 0T1847C, 0T1847D, 0T184J6, 0T184J7, 0T184J8, 0T184J9, 0T184JA, 0T184JB, 0T184JC, 0T184JD, 0T184K6, 0T184K7, 0T184K8, 0T184K9, 0T184KA, 0T184KB, 0T184KC, 0T184KD, 0T184Z6, 0T184Z7, 0T184Z8, 0T184Z9, 0T184ZA, 0T184ZB, 0T184ZC, 0T184ZD, 0T560ZZ, 0T563ZZ, 0T564ZZ, 0T567ZZ, 0T568ZZ, 0T570ZZ, 0T573ZZ, 0T574ZZ, 0T577ZZ, 0T578ZZ, 0T760ZZ, 0T763ZZ, 0T764ZZ, 0T768ZZ, 0T770ZZ,0T773ZZ, 0T774ZZ, 0T778ZZ, 0T780ZZ, 0T783ZZ, 0T784ZZ, 0T9000Z, 0T900ZZ, 0T9040Z, 0T9100Z, 0T910ZZ, 0T9140Z, 0T9300Z, 0T930ZZ, 0T9340Z, 0T9400Z, 0T940ZZ, 0T9440Z, 0T960ZX, 0T960ZZ, 0T964ZZ, 0T967ZZ, 0T968ZZ, 0T970ZX, 0T970ZZ, 0T974ZZ, 0T977ZZ, 0T978ZZ, 0T980ZX, 0T980ZZ, 0T984ZZ, 0T987ZZ, 0T988ZZ, 0TB60ZX, 0TB60ZZ, 0TB63ZZ, 0TB64ZZ, 0TB67ZZ, 0TB68ZZ, 0TB70ZX, 0TB70ZZ, 0TB73ZZ, 0TB74ZZ, 0TB77ZZ, 0TB78ZZ, 0TC60ZZ, 0TC63ZZ, 0TC64ZZ, 0TC70ZZ, 0TC73ZZ, 0TC74ZZ, 0TH902Z, 0TH90MZ, 0TH90YZ, 0TH932Z, 0TH93MZ, 0TH942Z, 0TH94MZ, 0TH97MZ, 0TH98MZ, 0TH98YZ, 0TJ50ZZ, 0TJ90ZZ, 0TL60CZ, 0TL60DZ, 0TL60ZZ, 0TL63CZ, 0TL63DZ, 0TL63ZZ, 0TL64CZ, 0TL64DZ, 0TL64ZZ, 0TL67DZ, 0TL67ZZ, 0TL68DZ, 0TL68ZZ, 0TL70CZ, 0TL70DZ, 0TL70ZZ, 0TL73CZ, 0TL73DZ, 0TL73ZZ, 0TL74CZ, 0TL74DZ, 0TL74ZZ, 0TL77DZ, 0TL77ZZ, 0TL78DZ, 0TL78ZZ, 0TM60ZZ, 0TM64ZZ, 0TM70ZZ, 0TM74ZZ, 0TM80ZZ, 0TM84ZZ, 0TN00ZZ, 0TN03ZZ, 0TN04ZZ, 0TN07ZZ, 0TN08ZZ, 0TN10ZZ, 0TN13ZZ, 0TN14ZZ, 0TN17ZZ, 0TN18ZZ, 0TN30ZZ, 0TN33ZZ, 0TN34ZZ, 0TN37ZZ, 0TN38ZZ, 0TN40ZZ, 0TN43ZZ, 0TN44ZZ, 0TN47ZZ, 0TN48ZZ, 0TN60ZZ, 0TN63ZZ, 0TN64ZZ, 0TN67ZZ, 0TN68ZZ, 0TN70ZZ, 0TN73ZZ, 0TN74ZZ, 0TN77ZZ, 0TN78ZZ, 0TP900Z, 0TP902Z, 0TP903Z, 0TP907Z, 0TP90CZ, 0TP90DZ, 0TP90JZ, 0TP90KZ, 0TP90MZ, 0TP90YZ, 0TP930Z, 0TP932Z, 0TP933Z, 0TP937Z, 0TP93CZ, 0TP93DZ, 0TP93JZ, 0TP93KZ, 0TP93MZ, 0TP940Z, 0TP942Z, 0TP943Z, 0TP947Z, 0TP94CZ, 0TP94DZ, 0TP94JZ, 0TP94KZ,

*Exclude principal diagnosis: T8351 (catheter-associated urinary tract infections)

Urology (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
S	Kidney & ureter procedures for neoplasm (cont.)	656 (cont.)	0TP94MZ, 0TP977Z, 0TP97CZ, 0TP97JZ, 0TP97KZ, 0TP97MZ, 0TP987Z, 0TP98CZ, 0TP98JZ, 0TP98KZ, 0TP98MZ, 0TP9XMZ, 0TQ60ZZ, 0TQ63ZZ, 0TQ64ZZ, 0TQ67ZZ, 0TQ68ZZ, 0TQ70ZZ, 0TQ73ZZ, 0TQ74ZZ, 0TQ77ZZ, 0TQ78ZZ, 0TR607Z, 0TR60JZ, 0TR60KZ, 0TR647Z, 0TR64JZ, 0TR64KZ, 0TR677Z, 0TR67JZ, 0TR67KZ, 0TR687Z, 0TR68JZ, 0TR68KZ, 0TR707Z, 0TR70JZ, 0TR70KZ, 0TR747Z, 0TR74JZ, 0TR74KZ, 0TR777Z, 0TR77JZ, 0TR77KZ, 0TR787Z, 0TR78JZ, 0TR78KZ, 0TS60ZZ, 0TS64ZZ, 0TS70ZZ, 0TS74ZZ, 0TS80ZZ, 0TS84ZZ, 0TT60ZZ, 0TT64ZZ, 0TT67ZZ, 0TT68ZZ, 0TT70ZZ, 0TT74ZZ, 0TT77ZZ, 0TT78ZZ, 0TU607Z, 0TU60JZ, 0TU60KZ, 0TU647Z, 0TU64JZ, 0TU64KZ, 0TU677Z, 0TU67JZ, 0TU67KZ, 0TU687Z, 0TU68JZ, 0TU68KZ, 0TU707Z, 0TU70JZ, 0TU70KZ, 0TU747Z, 0TU74JZ, 0TU74KZ, 0TU777Z, 0TU77JZ, 0TU77KZ, 0TU787Z, 0TU78JZ, 0TU78KZ, 0TV60CZ, 0TV60DZ, 0TV60ZZ, 0TV63CZ, 0TV63DZ, 0TV63ZZ, 0TV64CZ, 0TV64DZ, 0TV64ZZ, 0TV67DZ, 0TV67ZZ, 0TV68DZ, 0TV68ZZ, 0TV70CZ, 0TV70DZ, 0TV70ZZ, 0TV73CZ, 0TV73DZ, 0TV73ZZ, 0TV74CZ, 0TV74DZ, 0TV74ZZ, 0TV77DZ, 0TV77ZZ, 0TV78DZ, 0TV78ZZ, 0TW900Z, 0TW902Z, 0TW903Z, 0TW907Z, 0TW90CZ, 0TW90DZ, 0TW90JZ, 0TW90KZ, 0TW90MZ, 0TW90YZ, 0TW930Z, 0TW932Z, 0TW933Z, 0TW937Z, 0TW93CZ, 0TW93DZ, 0TW93JZ, 0TW93KZ, 0TW93MZ, 0TW940Z, 0TW942Z, 0TW943Z, 0TW947Z, 0TW94CZ, 0TW94DZ, 0TW94JZ, 0TW94KZ, 0TW94MZ, 0TW970Z, 0TW972Z, 0TW973Z, 0TW977Z, 0TW97CZ, 0TW97DZ, 0TW97JZ, 0TW97KZ, 0TW97MZ, 0TW980Z, 0TW982Z, 0TW983Z, 0TW987Z, 0TW98CZ, 0TW98DZ, 0TW98JZ, 0TW98KZ, 0TW98MZ,0TW98YZ, 0WBH0ZZ, 0WBH3ZZ, 0WBH4ZZ, 0WQF0ZZ, 0WQF3ZZ, 0WQF4ZZ
		657	See MS-DRG 656
		658	See MS-DRG 656
S	Kidney & ureter procedures for non-neoplasm	659	See MS-DRG 656
		660	See MS-DRG 656
		661	See MS-DRG 656
S	Minor bladder procedures	662	Include all
		663	Include all
		664	Include all
S	Prostatectomy	665	Include all
		666	Include all
S	Transurethral procedures	668	Include all
		669	Include all
S	Urethral procedures w CC/MCC	671	Include all
S	Other kidney & urinary tract procedures	673	Include procedures: 0VPS0JZ, 0VPS3JZ, 0VPS4JZ, 0VPS7JZ, 0VPS8JZ, 0VUS0JZ, 0VUS4JZ
		674	See MS-DRG 673
		675	See MS-DRG 673

*Exclude principal diagnosis: T8351 (catheter-associated urinary tract infections)

Urology (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Kidney & urinary tract neoplasms	686	Exclude diagnoses: C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C79.00, C79.01, C79.02, C7A.093, D30.00, D30.01, D30.02, D30.10, D30.11, D30.12, D3A.093
		687	See MS-DRG 686
		688	See MS-DRG 686
M	Urinary stones w esw lithotripsy	691	Include all
		692	Include all
M	Urethral stricture	697	Include all
M	Other kidney & urinary tract diagnoses	698	Exclude diagnoses: E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I70.1, I72.2, I75.81, I77.73, I82.3, M10.30, M10.311, M10.312, M10.319, M10.321, M10.322, M10.329, M10.331, M10.332, M10.339, M10.341, M10.342, M10.349, M10.351, M10.352, M10.359, M10.361, M10.362, M10.369, M10.371, M10.372, M10.379, M10.38, M10.39, N00.0, N00.1, N00.2, N00.3, N00.4, N00.5, N00.6, N00.7, N00.8, N00.9, N01.0, N01.1, N01.2, N01.3, N01.4, N01.5, N01.6, N01.7, N01.8, N01.9, N02.0, N02.1, N02.2, N02.3, N02.4, N02.5, N02.6, N02.7, N02.8, N02.9, N03.0, N03.1, N03.2, N03.3, N03.4, N03.5, N03.6, N03.7, N03.8, N03.9, N04.0, N04.1, N04.2, N04.3, N04.4, N04.5, N04.6, N04.7, N04.8, N04.9, N05.0, N05.1, N05.2, N05.3, N05.4, N05.5, N05.6, N05.7, N05.8, N05.9, N06.0, N06.1, N06.2, N06.3, N06.4, N06.5, N06.6, N06.7, N06.8, N06.9, N07.0, N07.1, N07.2, N07.3, N07.4, N07.5, N07.6, N07.7, N07.8, N07.9, N08, N14.0, N14.1, N14.2, N14.3, N14.4, N15.0, N15.8, N15.9, N16, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.9, N27.0, N27.1, N27.9, N28.0, N28.1, N28.81, N28.83, N28.9, N29, R80.2, S37.001A, S37.002A, S37.009A, S37.011A, S37.012A, S37.019A, S37.021A, S37.022A, S37.029A, S37.031A, S37.032A, S37.039A, S37.041A, S37.042A, S37.049A, S37.051A, S37.052A, S37.059A, S37.061A, S37.062A, S37.069A, S37.091A, S37.092A, S37.099A, Z52.4, Z94.0
		699	See MS-DRG 698
		700	See MS-DRG 698
S	Major male pelvic procedures	707	Include all
		708	Include all
S	Penis procedures	709	Include all
		710	Include all
S	Testes procedures	711	Include all
		712	Include all
S	Transurethral prostatectomy w CC/MCC	713	Include all
S	Other male reproductive system O.R. proc for malignancy	715	Include all
		716	Include all
S	Other male reproductive system O.R. proc exc malignancy	717	Include all
		718	Include all
M	Malignancy, male reproductive system	722	Include all
		723	Include all
		724	Include all

*Exclude principal diagnosis: T8351 (catheter-associated urinary tract infections)

Urology (cont.)*

Medical/ Surgical	DRG Title	MS-DRG	ICD-10
M	Inflammation of the male reproductive system	727	Include all
		728	Include all
M	Other male reproductive system diagnoses	729	Exclude diagnoses: Z30.2
		730	See MS-DRG 729
S	Prostatic O.R. procedure unrelated to principal diagnosis	984	Include all
		985	Include all
		986	Include all

*Exclude principal diagnosis: T8351 (catheter-associated urinary tract infections)

Appendix C

Year-by Year History of Methodology Changes

RTI began working with *U.S. News* on the Best Hospitals rankings in 2005. This section details the changes to the previous Best Hospitals methodology used between 2005-2022. These brief descriptions are provided for context to allow consumers of the rankings to review year-over-year changes implemented to the rankings.

Summary of 2022-2023 Changes

- **Adjustments related to the COVID-19 pandemic:** We excluded visits in which a patient had a diagnosis of COVID-19. For each hospital's outcome measures, we also excluded visits from March 2020 and for other months in 2020 in which the hospital's COVID-19 rate exceeded the national average or exceeded 15%, whichever was less. In addition, for hospitals with higher volume in 2017-2019 than in 2018-2020, we calculated volume measures using observed volumes from 2017-2019.

- **Removal of CLABSI and/or CAUTI cases in three specialties:** In Cardiology and Heart Surgery, any case with primary diagnosis of CLABSI (central-line-associated bloodstream infections) was removed from analysis. In Geriatrics, any case with a primary diagnosis of CLABSI or CAUTI (catheter-associated urinary tract infections) was removed from analysis. In Urology, any case with a primary diagnosis of CAUTI was removed from analysis.

- **Updated Obstetrics & Gynecology specialty:** The name of the specialty was changed to Obstetrics & Gynecology in recognition of changes to the specialty. This specialty now includes a new transparency indicator that is based on participation by hospitals in public reporting on the U.S. News Maternity Services Survey. Hospitals that participated in this public reporting received credit for the transparency indicator which is now worth 3% of their total U.S. News Score for this ranking.

- **Update to Cardiology and Heart Surgery specialty:** This specialty replaced the structural eligibility requirements from the AHA annual survey with a new indicator that the hospital offered cardiac surgical services from the U.S. News Procedures & Conditions ratings. Hospitals that qualified for any rating in AVR and CABG in 2021-2022 were eligible for this specialty if they met the volume and expert opinion requirements listed earlier in this report. Also, the Patient Services measure was updated to include a measure of whether the hospital offered a cardiac intensive care unit (CICU) as part of the services available to patients.

- **Update to Honor Roll & Best Regional Hospitals:** Three new cohorts were added to the Honor Roll and Best Regional Hospitals in 2022-2023. These include ovarian, uterine, and prostate cancer surgery. The ovarian and uterine cancer surgery cohorts were combined for these lists and considered together in the same way that AVR and TAVR are considered as a single group. This effectively increases the number of possible points for hospitals by two cohorts. See the detailed description in the proceeding section.

Summary of 2021-2022 Changes

- **Introduction of a new data-driven inpatient Rehabilitation ranking**. The previous rehabilitation ranking has been expanded to include additional process, outcome, and structural measures introducing a new version of the ranking for 2021-2022 that makes use of a data-driven methodology. As additional measures of rehabilitation care become available for use, the project will continue to expand the set of measures used to evaluate hospitals in this area.

- **Refined the Discharge to Home measure.** For the "discharge to home" outcome measure, two small changes were made to the analyses this year to refine the focus on only relevant cases. First, we removed all admissions from skilled nursing facilities (SNF, clm_src_ip_admsn_cd=5) from the denominator. Second, we removed all discharges to home hospice (ptnt_dschrg_stus_cd=50) from the denominator.

- **Nurse staffing adjustments.** Beginning with the 2021-2022 rankings, nurse staffing is averaged over three years to reduce the impact of year-to-year variation in reporting. For example, the 2021-2022 rankings created an average of the nurse staffing index values as calculated from the 2017, 2018, and 2019 AHA databases.

Summary of 2020-2021 Changes

- **Updates to the Risk Adjustment of the Mortality and Discharge to Home Scores.** For the 2020-2021 rankings, all covariates were the same as was used in the 2019-2020 rankings with the exception of the removal of the ICD version. All years of data incorporated in the 2020-2021 rankings used ICD-10 codes, so this covariate was no longer needed in the model.

- **Move to Calendar Year for Medicare Data.** For all Medicare data used in the project, we switched from fiscal to calendar year. We made this change for two reasons. First, to harmonize the specialty hospital rankings with the Procedures & Conditions ratings, where calendar year data has been used for a number of years. Second, calendar year data is three months more recent than the corresponding fiscal year data, so this change ensured that more up-to-date data were used for the rankings.

- **Accounting for Medicare Advantage in Volume Measures.** To measure hospital volume in each specialty, we used volume counts from the MedPAR datasets, which includes patients who have Medicare Advantage insurance, to adjust volumes to account for Medicare cases missing from the SAF datasets. For hospitals that treat Medicare Advantage patients, using this adjustment produced a more precise measure of volume and removed the need to use county-level Medicare Advantage penetration rate, as we have done in the past, to adjust Medicare fee-for-service volume. In a small number of cases, MedPAR data was not available, so the county-level Medicare Advantage penetration rate was used to estimate the adjustment to the volume.

- **Discharge to Home Update.** For the "discharge to home" outcome measure, patients who received nonsurgical care and were discharged to home hospice (discharge status code 50) are now treated as having been discharged to home. We changed our approach due to feedback we received stating that for patients who are dying (such as patients with advanced cancer), being discharged to home hospice is often the best patient-centered outcome. Additionally, all patients who were discharged home with planned readmission (discharge status codes 81 or 86) are now treated as having been discharged to home. Patients with any of several rare codes indicating the involvement of a court or law enforcement agency were excluded from the measure.

- **Stroke Registry Transparency Measure.** A new measure of public transparency was added in Neurology & Neurosurgery. The hospitals that opted-in by the December 2019 deadline to publicly report performance measures from the American Heart Association's Get With The Guidelines-Stroke program received credit if evaluated in this specialty. The weight assigned to this transparency measure was 2 percent, and the weight assigned to Expert Opinion in this specialty was reduced by the same amount.

Summary of 2019-2020 Changes

- **Update of the Mortality Measure and Survival Score**. Starting with 2019-2020, the rankings moved to a new mortality measure as the basis of the survival score. The new measure utilizes risk-adjustment methodologies developed in the Best Hospitals for Procedures & Conditions project to evaluate one of the most important outcomes of care—whether patients live or die as a result of inpatient hospitalization. The new methodology utilizes multilevel logistic regression models to adjust for differences in case mix between hospitals. The model calculates RE (random effect) scores which can be thought of as a hospital level off-set. They represent the risk difference between a hospital and all hospitals in a given specialty, discounted by the reliability of that difference (based on the volume of cases). The models make use of a variety of covariates such as patient age, gender, Medicare status, the year of the visit, Elixhauser comorbidities, dual eligibility for Medicare and Medicaid (a proxy measure of socio-economic status), the DRG group of the claim, and an indicator of whether the claim was coded in ICD-9 or ICD-10 to account for differences in coding practices.

- **Addition of the Discharge to Home Score**. A new outcome for 2019-2020 rankings is the discharge to home score, which assesses how well a hospital does at managing to discharge patients to home rather than sending them on to another acute, post-acute, or long-term care setting following hospitalization. This measure provides unique information about hospital outcome performance that has been available in the Best Hospitals for Procedures & Conditions ratings for a number of years but is new to the Best Hospitals Specialty Rankings.

- **Removal of the Patient Safety Score**. Since 2009, the Best Hospitals Specialty Rankings have included a patient safety score, which were constructed from a

selection of Patient Safety Indicators (PSIs). The PSIs that constituted the patient safety score have evolved over time as our understanding of the validity and reliability of individual PSIs has changed. For 2019-2020, we removed the patient safety score from the methodology. While the construct of patient safety remains important, we concluded that these specific measures are not ideal for comparing hospital performance.

- **Addition of Patient Experience Score**. In response to feedback from patients, hospital leaders and other stakeholders about the importance of the patient experience when considering healthcare quality, we introduced the patient experience score. This score is based on the linear mean score data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey.

- **Removal of DRG 470 from orthopedics.** This DRG, which includes hip and knee replacement, was removed from the Best Hospitals rankings because it overlaps with cases included in the Best Hospitals for Procedures & Conditions ratings. These low-risk procedures generally do not require complex specialty care, and some health systems are increasingly treating these cases in settings different from those where complex orthopedic care is delivered.

Summary of 2018-2019 Changes

- **Removal of the transfer adjustment for mortality**. Since 2010, the rankings have adjusted mortality ratios for the influence of particularly high or low transfer rates to control for potential bias in the evaluation of hospital outcomes. This was done to address issues with coding of transfers in the datasets used which had been shown to be problematic at times. With the move to the SAF data, the project is now able to use both identified transfers on the record along with calculated implicit transfers which effectively overcomes the previous issues, removing the need for the adjustment.

- **Backwards mapping of ICD-10 to ICD-9**. Since two of the three years of SAF data used in the rankings for 2018-19 appear in ICD-9 format, the project chose to recode the ICD-10 data from FY2016 into ICD-9 format for the volume and mortality analyses. Due to the increased granularity of the ICD-10 codes, it is possible to backwards map ICD-10 codes to ICD-9 codes. The project team utilized the IBM Watson Health mapping of ICD-10 to ICD-9 codes to recode data, so that the same DRGs could be used for all three years. The project anticipates using the same approach for the 2019-2020 rankings before moving completely to ICD-10 in 2020. (See page 26-27.)

- **Updated Survival Score calculation**. To improve the clarity of the survival scores used in the data-driven specialties, the project team updated the method of calculating these display-only scores (this change does not affect points assigned in the rankings). The scores are now calculated based on the adjusted mortality ratio (rather than the unadjusted ratio) and are based on quintiles above and below a

mortality ratio of 1.0; ratios above 1.0 will receive a score of 1-5, while those below a ratio of 1.0 will receive a score of 6-10. (See pages 31-32.)

Summary of 2017-2018 Changes

- **Move to SAF data**. The project implemented a change from the MedPAR to the SAF inpatient limited datasets for all volume, mortality, and patient safety calculations; the exception is that the HSCRC all-payer database continued to be used for the Patient Safety Score calculations for hospitals located in Maryland. Only patients receiving care under traditional Medicare (fee-for-service) are included in the SAF data used for analyses; as a result, all hospital volumes will be reduced due to the lack of CMS managed care patients in the SAF data.

- **Volume adjustment for loss of Medicare Advantage**. Volumes were estimated for hospitals in each specialty using an adjustment to account for the loss of Medicare Advantage patients from the analyses. The numerator for the volume calculation was the number of fee-for-service discharges meeting the criteria for inclusion in the specialty. The denominator was the proportion of Medicare beneficiaries enrolled in fee-for-service (as opposed to Medicare Advantage) in the county in which the hospital is located. The denominator was calculated by subtracting from 1.0 the CMS Medicare Advantage penetration estimates, expressed as a decimal less than 1.0, for June 2013. As a result, the volumes reported represent estimates rather than observed volumes of care at each hospital.

- **Socioeconomic status (SES) adjustment to the survival score.** The rankings now incorporate a new adjustment at the patient level for dual-eligibility for Medicare and Medicaid. The dual eligible flag is set to either 0 (not present) or 1 (present) for each case entering the risk-adjusted mortality equation. This was done to address known differences in morbidity and mortality with hospital patients associated with lower SES; dual-eligibility, or more specifically eligibility for Medicaid, is being used in this case to represent lower SES. The overall impact of the change is very small, but will result in scores that better represent patient survival in hospitals evaluated.

- **Intensivists**. Hospitals now receive 1 point for having at least one intensivist FTE reported as being available in any adult-focused intensive care unit within the hospital. This change now provides somewhat broader credit to hospitals for having intensivists available than in previous years.

- **Nurse Magnet**. The Nurse Magnet measure was updated to better reflect program coverage for hospitals that are part of a multi-campus system or an arrangement with another hospital outside the system. Hospitals received 1 point for being recognized as a Nurse Magnet hospital. For hospitals that are part of a special merger or a multiplex healthcare system, the primary hospital is required to have Magnet Recognition status for the combination hospital to receive 1 point. If there is no defined primary hospital, then if either hospital in the special merger has Magnet Recognition status then both receive credit. Partial credit was not offered in the 2017-2018 rankings.

- **Patient safety score.** Two of the PSIs used in the patient safety score—PSI 06 (Iatrogenic Pneumothorax) and PSI 14 (Postoperative Wound Dehiscence)—were dropped due to concerns that low base rates could lead to unreliable measurement. The scoring for the remaining individual PSIs was also revised to a three-point scale with the middle category defined as the mean +/- 2 standard deviations. The individual PSI scores were combined to form a 1-9-point Patient Safety Score with higher numbers indicating better performance (i.e., lower rates of patient safety events).

- **Nurse staffing score adjustments.** The project implemented three changes to the nurse staffing score for the 2017-18 rankings. First, the calculation now includes a correction for hospitals that provide onsite skilled nursing and report their nursing inclusive of both the inpatient and skilled nursing. The nursing FTEs associated with the skilled nursing are removed from the numerator and a corrected adjusted average daily census is used for the denominator. The corrected adjusted average daily census values for hospitals affected by this change are calculated and provided directly to the project by the AHA. Second, to address problems with missing data—in particular the primary nursing FTEs variable (FTEN)—the rankings impute missing FTEN values. For the imputation, hospitals that do not have extreme nurse staffing ratios are selected and the calculation incorporates data from current values for FTEN (Full time equivalent registered nurses reported), FTERN (Full time equivalent registered nurses estimated), ADJADC (Adjusted Average Daily Census) and BDTOT (total hospital beds set up and staffed). Third, to address volatility in the nurse staffing measure for hospitals with relatively low numbers of patients, we adjust the nurse staffing values for hospitals in the lowest quartile of adjusted average daily census by blending their rate with that of the average adjusted nurse staffing rate for hospitals eligible for the rankings.

- **Surgical Minimums for Eligibility in Neurology and Neurosurgery.** To be eligible for evaluation in the neurology and neurosurgery specialty hospitals are now required to be at the 25th percentile or higher in terms of the ratio of surgical to total discharges within the DRGs evaluated for the specialty. This change was made to address excessive bias in mortality rates for hospitals with a very low ratio of surgical-to-total discharges.

Summary of 2016-2017 Changes

- **MedPAR data**. Only patients receiving care under Medicare (fee-for-service and, if available, managed-care) and who were 65 years of age or older were included in the MedPAR file used for analyses. In previous years, all ages were used which resulted in somewhat inflated volume rates.

- **Component weight**. The overall weight for the patient safety index was lowered from 10% in 2015-16 to 5% in 2016-17. The overall weight for outcomes was correspondingly increased from 32.5% last year to 37.5%.

- **Intensivists**. Hospitals now receive 1 point for having at least one intensivist whether on staff or through another privileged arrangement. Previously, intensivists were required to be on staff.

- **Nurse Magnet**. The Nurse Magnet measure was updated to better reflect program coverage for hospitals that are part of a multicampus system or an arrangement with another hospital outside the system. These combined entities only received full credit in 2016-17 (1 point) if all hospitals in the combination had Nurse Magnet recognition as of April 1, 2016. If the primary hospital had Nurse Magnet recognition but the specialty or secondary hospital(s) did not, the combined entity received half credit (0.5 point).

- **Public transparency**. In Cardiology & Heart Surgery only, a new measure was added rewarding hospitals for participation in transparency in public reporting of heart outcomes with the ACC and STS.

- **Use of SAF data for patient safety**. In previous years, the data source for the patient safety score was the same 3-year sample from the MedPAR dataset that was used for the volume and mortality analyses. For 2016-17, the rankings used data from the CMS SAF data instead of MedPAR. This change was motivated by the need to have more accurate procedure data for a number of the PSI calculations.

- **Patient safety score.** PSI 03, decubitus ulcer, was dropped due to concerns that the measure was overly sensitive to missing POA data in the record, which could confound comparisons.

- **Data for Maryland hospitals**. For Maryland hospitals, data from the state's HSCRC all-payer database were used for patient safety. This change was made to address incomplete coding of POA indicators in the CMS datasets for some of the years of analyses under consideration for the rankings.

- **Honor Roll.** Moved to a new format that incorporated results from the 12 data-driven specialty rankings, the 4 expert opinion-based specialty rankings, and the 9 procedures and conditions ratings. Hospitals received points for being ranked in each of the Best Hospitals data-driven and expert opinion only specialties if they appeared in the top 50, and additional points if they achieved a rating of high performing in the procedures and conditions ratings. The Honor Roll now recognizes the 20 hospitals that earned the most points out of the possible total.

Summary of 2015-2016 Changes

- **Technology and Patient Services**. Due to changes to the AHA annual survey, there are now three categories instead of four categories for receiving credit for providing technology and patient services to patients. These services can be provided (1) by the hospital or its subsidiaries, (2) by the hospital's health system (in local network), or (3) by another institution outside of the health system, but in the local network, through a formal contractual arrangement or joint venture.

- **Patient Safety Score.** PSI08 was removed from the patient safety score due to low prevalence. A risk-adjusted rather than a smoothed rate is used, to address concerns that the smoothed rate might over-adjust for differences between hospitals.

Summary of 2014-2015 Changes

- **Component weighting.** The weight for the process component was reduced from 32.5% to 27.5% and the weight for the patient safety score was increased from 5% to 10%. This was done in recognition of the increased importance of patient safety to the quality of care provided by hospitals.

- **Technology**. Cardiac ICU was removed in Cardiology & Heart Surgery, as it already served as a requirement for hospitals to be eligible for ranking in this specialty. IMRT was added as a new technology to the Cancer and Urology specialties, recognizing the importance of this treatment modality to care in both specialties.

- **Patient Safety Score.** Two patient safety indicators were added to the patient safety score due to the availability of the POA indicator in the MedPAR dataset. Additionally, for display purposes, PSIs were converted from a 3-point scale to a 5-point scale to provide more nuanced information to consumers on the differences in patient safety performance between hospitals. For scoring, we now use a continuous value for PSI rather than a discrete value shown in the ranking tables.

- **MS-DRG deletions.** MS-DRG 689 (Kidney and Urinary Tract Infections with MCC) was removed from the Urology specialty because it does not reflect the quality of care of a urology service. A review of hospital data showed that the code is frequently used by other specialties within the institution to identify significant medical comorbidities rather than for identifying performance by the institution's urology service.

- **Eligibility for expert opinion-based specialties**. In previous years, a hospital was eligible if it received one or more physician nominations in the past 3 years. In 2014-15, a hospital was eligible for an expert opinion-based specialty only if it had an expert opinion score of 1% or greater. This change was made to restrict eligibility to hospitals that are more consistently nominated.

Summary of 2013-2014 Changes

- **"Present on admission" data included in patient safety calculations.** Starting with the 2013-14 rankings, patient safety data were analyzed using the AHRQ PSI grouper software version 4.3. This version of the software incorporates POA data found in Medicare claims. This allows the software to remove cases where POA is indicated so that they do not count against a hospital in the assessment of patient safety events.

- **Neurology & Neurosurgery MS-DRG deletions.** Several procedures involving spinal fusion (MS-DRGs 028, 029, 030, 453, 453, 455, 456, 457, 458, 459, 460, 471,

472, 473, 490, and 491) were removed from the Neurology & Neurosurgery but retained in the Orthopedic specialty. The change was made to reflect the specialty that patients typically turn to when seeking spinal fusion procedures. This change also eliminated a redundancy in the coverage of these procedures in the rankings. As a result, these procedures are covered in the orthopedic specialty regardless of whether the surgery was performed by an orthopedic surgeon or neurosurgeon.

Summary of 2012-2013 Changes

- **Surgical volume discharge minimums.** If the minimum total discharge value for a specialty was lower than 25, then 25 was set as the minimum for that specialty to ensure a sufficient number of discharges.

- **Normalization.** Normalization is the process of transforming index values into a distribution between 0 and 1 based on the range of possible values for a given measure. Individual measures were normalized before incorporating into the overall score. In previous years, standardization was used instead of normalization.

- **New weighting procedures for structural measures.** In previous years, factor analysis determined the relative weights of the structural measures. Starting in 2012-13, weights are based on the relative significance of each measure.

- **Expert Opinion.** In previous years, the hospital with the highest expert opinion score received the full point total (i.e., 32.5 points) for the expert opinion component. Starting in 2012-13, hospitals received a normalized expert opinion score. For example, if the highest expert opinion score in a given specialty is 80%, the hospital receives a normalized score of 0.80. Since expert opinion is worth 32.5% of the overall score, the hospital receives 0.80 x 32.5, or 26 points, for expert opinion instead of the full 32.5 points possible.

- **Survey response weighting.** Beginning in 2012-13, we calculated expert opinion values for each year of the survey independently and averaged the 3 years rather than pooling nominations across years. This was done to reduce the year-to-year fluctuation of expert opinion scores within specialties.

- **Honor Roll.** The methodology for assigning Honor Roll points was revised. For data-driven specialties, hospitals received 2 points for ranking among the top 10 hospitals and 1 point for ranking in the next 10 (i.e., 11–20). For expert opinion-based specialties, hospitals received 2 points for ranking in among the top 5 and 1 point for ranking in the next 5 (i.e., 6–10).

Summary of 2011-2012 Changes

- **Ties allowed.** For 2011-12, we instituted a new rule that allows for ranking ties for hospitals with the same score. Previously, ties were not allowed and were broken by examining the scores out to 3 decimal points.

- **Cut-offs for expert opinion-based specialties.** In previous years, hospitals representing 3% or more of the total nominations in a specialty were published in print for the expert opinion-based specialties. For the 2011-12 rankings, this was revised to 5% to be more discerning.

- **Mortality displayed as survival scores.** The values displayed in the rankings tables for mortality were changed from mortality ratios to decile-based survival scores. The top 10% of hospitals—with the lowest relative mortality and highest 30-day survival—received a survival score value of 10; the next 10% of hospitals received a value of 9, and so on. The method for using the mortality scores to calculate the score did not change from that used in 2010.

- **Updated scoring for the Patient Safety Index**. The Patient Safety Index was revised to include 6 rather than 7 indicators (PSI 02: Death in low-mortality DRGs is no longer included). The approach to weighting individual PSIs also changed from the population at risk to equal weighting. The index scoring was also updated from the quintile scoring used in 2009-10 to a new 3-point scale that represents ≥ 75th percentile, 25th–74th percentile and < 25th percentile.

Summary of 2010-2011 Changes

- **Expert opinion scores transformed.** Implemented a new log transformation of the expert opinion survey data prior to standardization. This change will allow expert opinion scores to cluster more, reducing the overall impact of this component on the final hospital ranking.

- **MS-DRGs incorporated.** The 3M Health Information Systems MS Grouper software was run on all 3 years of data included in the analyses, and we revised the assignment of cases to specialties using the MS-DRGs.

- **Change in structural volume measure.** The criteria used to determine volume for the structural variable have now changed to include only those cases meeting the minimum severity of illness thresholds set by the project using APR-DRGs and includes transfers; previously, this measure focused on all discharges for DRGs used by the project and excluded transfers. This change will allow the volume measure to more accurately reflect the actual volume of cases according to the specialty definitions.

- **Codes identifying transfers for mortality calculation revised.** As in previous years, transfers were identified using the claim source of inpatient admission variable on the MedPAR files. In past years, transfers were identified based on the value "4" for transfer from an acute hospital. This year the variable value "A" for transfer from critical access hospital was also used.

- **Low-discharge hospitals adjustment changed.** We revised the method for adjusting the scores for hospitals with low discharges on both volume and mortality. In previous years, we used an inverse-logit transformation. Starting in 2010, for hospitals with a discharge volume below the 25th percentile, we adjusted the observed

volume score and transfer-free mortality rate by creating an average weight based on the hospital's observed score and the score for all hospitals at or above the 25th percentile in volume.

- **"Outlier" transfer data adjusted.** We adjusted the observed transfer-free mortality rate for hospitals in the top and bottom quartiles of transfer-in rates to account for the fact that some hospitals may have had too many or too few cases included in the mortality calculations due to poor or inaccurate coding of administrative data.

Summary of 2009 Changes

- **Eligibility criteria updated.** Hospitals with a minimum number of hospital beds may now be eligible for the rankings.
- **Key technologies updated.** The elements in this index were updated for a few specialties to remain consistent with the key technologies expected from a best hospital.
- **Intensivist on staff added.** Hospitals now receive credit in all data-driven specialties for having intensivists on staff.
- **Patient Safety Index added.** A Best Hospitals Patient Safety Index was created and applied to all data-driven specialties.
- **DRG groupings updated.** DRG groupings were updated for all data-driven specialties, consistent with typical year-to-year changes.
- **Physician survey.** The following instruction was removed from the physician survey: "Please do not list any hospital where you currently practice." Physicians likely choose to work at a certain hospital because it is a best hospital. Therefore, it was deemed acceptable for them to vote for the hospital where they work.

Summary of 2008 Changes

- **Advanced technologies updated.** The elements in this index were updated for a few specialties to remain consistent with the advanced technologies expected from a best hospital.
- **Patient services updated.** The elements in these services were updated for a few specialties to remain consistent with the patient services expected from a best hospital.
- **Trauma center certification dropped.** Trauma center certification was dropped from the Gynecology specialty.
- **Alzheimer's disease center added.** This element was added to the Neurology & Neurosurgery specialty.

- **30-day mortality rates added for Cancer.** Thirty-days-from-admission mortality rates were introduced in all data-driven specialties except Cancer in 2007. For 2010-11, 30-day mortality was used in Cancer as well.

Summary of 2007 Changes

Changes for 2007 were more substantial but still in keeping with the goal of maintaining consistency and continuity. Many of the changes were discussed at length at a day-long meeting convened by U.S. News in fall 2006 to solicit the views of a Best Hospitals advisory panel of approximately 40 invitees. The panelists represented top hospitals and brought expertise in areas such as clinical care, healthcare data analyses and quality research. Several representatives from key trade/industry organizations also participated.

- **External organizations added.** Hospitals in the Cancer specialty now receive points for accreditation by FACT as a Cellular Therapy Facility. Hospitals in Geriatrics now receive points if they are recognized by NIA for having an Alzheimer's center.
- **DRG groupings updated.** DRG groupings were updated for all specialties, consistent with typical year-to-year changes.
- **Transfers excluded.** Patients transferred into a hospital from another hospital are excluded from mortality and volume calculations to reduce the likelihood of either benefiting or suffering from "dumping" of patients.
- **30-day mortality introduced.** Thirty-days-from-admission mortality rates were introduced in all data-driven specialties (except Cancer) instead of death-at-discharge mortality rates.
- **Mortality data weighted.** Weights were applied to the MedPAR data based on the relative over- or underrepresentation of the cases' DRGs among all patients, as identified in the HCUP data.
- **Neonatologists moved.** Neonatologists were removed from the Gynecology sample and included in the Pediatrics sample instead.
- **Physician survey.** An additional instruction was added to the physician survey: "Please do not list any hospital where you currently practice."

Summary of 2005 and 2006 Changes

To maintain consistency in the previous ranking process, RTI replicated the preexisting methodology in the 2005 rankings and implemented only minor operational improvements in 2006.

Appendix D

2023-2024 Best Hospitals Rankings, Data-Driven Specialties

Best Hospitals 2023-24: Cancer

Rank	Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Recognized as Nurse Magnet hospital	NCI-designated cancer center	Accredited by FACT	Expert opinion	Current AHA responder
1	University of Texas MD Anderson Cancer Center, Houston	100.0	5	5	5	12,941	2.0	Yes	8	8	1	Yes	2	30.7	Yes
2	Memorial Sloan Kettering Cancer Center, New York	92.8	5	5	5	6,578	2.5	Yes	8	8	1	Yes	2	28.8	Yes
3	Mayo Clinic, Rochester, Minn.	87.3	5	5	5	4,377	3.1	Yes	8	8	1	Yes	2	14.8	Yes
4	UCLA Medical Center, Los Angeles	86.5	5	5	5	1,978	3.1	Yes	8	8	1	Yes	2	4.4	Yes
5	Dana-Farber/Brigham and Women's Cancer Center, Boston	81.0	5	5	5	4,200	2.3	Yes	8	8	1	Yes	2	17.6	Yes
6	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	80.0	5	5	4	3,437	2.8	Yes	8	8	1	Yes	2	6.3	Yes
7	UCSF Health-UCSF Medical Center, San Francisco, Calif.	79.4	5	5	4	2,670	2.4	Yes	8	8	1	Yes	2	5.8	Yes
8	City of Hope Comprehensive Cancer Center, Duarte, Calif.	79.0	5	5	5	2,067	2.4	Yes	8	8	1	Yes	2	4.7	Yes
9	Johns Hopkins Hospital, Baltimore	77.9	5	5	5	2,189	2.7	Yes	8	8	1	Yes	2	10.0	Yes
10	Cleveland Clinic	76.9	5	5	4	3,553	2.3	Yes	8	8	1	Yes	2	6.3	Yes
11	Stanford Health Care-Stanford Hospital, Stanford, Calif.	76.8	5	5	5	2,635	3.7	Yes	8	8	1	Yes	2	4.0	Yes
12	Mount Sinai Hospital, New York	76.7	5	5	3	2,447	2.4	Yes	8	8	1	Yes	2	1.4	Yes
13	New York-Presbyterian Hospital-Columbia and Cornell	76.5	5	5	4	5,078	3.0	Yes	8	8	1	Yes	2	3.2	Yes
14	Cedars-Sinai Medical Center, Los Angeles	74.7	5	5	4	2,032	2.9	Yes	8	8	1	No	2	1.5	Yes
15	USC Norris Cancer Hospital-Keck Medical Center of USC, Los Angeles	74.0	5	5	5	1,180	2.6	Yes	8	8	1	Yes	2	2.1	Yes
16	University of Chicago Medical Center	73.0	5	5	4	2,376	2.4	Yes	8	8	1	Yes	2	3.2	Yes
17	Beth Israel Deaconess Medical Center, Boston	72.3	5	5	4	2,272	1.4	Yes	8	8	1	Yes	2	0.5	Yes
18	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	71.8	5	5	4	2,635	2.0	Yes	8	8	1	Yes	2	2.4	Yes
19	UT Southwestern Medical Center, Dallas	70.9	5	5	5	2,233	2.4	Yes	8	8	1	Yes	2	1.2	Yes
20	Houston Methodist Hospital	70.5	5	5	4	1,870	2.1	Yes	8	8	1	No	2	0.3	Yes
20	UC San Diego Health-Moores Cancer Center	70.5	5	5	4	1,869	2.2	Yes	8	8	1	Yes	2	1.6	Yes
22	Perlmutter Cancer Center at NYU Langone Hospitals, New York	70.2	5	5	4	3,183	2.3	Yes	8	8	1	Yes	2	1.8	Yes
23	Siteman Cancer Center at Barnes-Jewish Hospital, Saint Louis	70.0	5	5	4	4,557	2.0	Yes	8	8	1	Yes	2	3.7	Yes
24	Mayo Clinic-Phoenix	69.8	5	5	5	1,564	2.3	Yes	8	8	1	Yes	2	2.1	Yes
25	UPMC Presbyterian Shadyside, Pittsburgh	69.6	5	5	4	4,405	2.4	Yes	8	8	1	Yes	2	2.9	Yes
26	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	69.4	5	5	3	1,933	2.9	Yes	8	8	1	No	2	0.3	Yes
27	Mayo Clinic-Jacksonville, Fla.	68.8	5	5	5	1,474	2.6	Yes	8	8	1	Yes	2	2.4	Yes
28	Massachusetts General Hospital, Boston	68.5	5	5	5	3,447	2.6	Yes	8	8	1	Yes	2	6.8	Yes
29	Duke University Hospital, Durham, N.C.	67.5	5	5	5	2,484	2.2	Yes	8	8	1	Yes	2	4.1	Yes
30	Rush University Medical Center, Chicago	67.0	5	5	4	1,641	1.8	Yes	8	8	1	No	2	0.6	Yes
31	H. Lee Moffitt Cancer Center and Research Institute, Tampa	66.8	5	5	5	2,227	1.1	Yes	8	8	1	Yes	2	5.8	Yes
32	OHSU Hospital-Knight Cancer Institute, Portland, Ore.	64.6	5	5	4	1,664	2.2	Yes	8	8	1	Yes	2	0.8	Yes
33	Ohio State University James Cancer Hospital, Columbus	63.5	5	5	5	4,458	2.1	Yes	8	8	1	Yes	2	4.3	Yes
34	University of Michigan Health Rogel Cancer Center, Ann Arbor	63.4	5	5	5	2,644	2.7	Yes	8	8	1	Yes	2	3.2	Yes
35	Montefiore Medical Center, Bronx, N.Y.	63.1	5	5	3	2,371	2.0	Yes	8	8	0	Yes	2	0.7	Yes
36	UC Davis Medical Center, Sacramento, Calif.	62.7	5	5	4	1,626	2.8	Yes	8	8	1	Yes	2	0.7	Yes
37	M Health Fairview University of Minnesota Medical Center, Minneapolis	62.3	5	5	4	1,220	2.0	Yes	8	8	0	Yes	2	0.5	Yes
38	Fred Hutchinson Cancer Center/University of Washington Medical Center, Seattle	62.0	5	5	4	2,418	2.1	Yes	8	8	1	Yes	2	5.0	Yes
39	University Hospitals Seidman Cancer Center, Cleveland	61.9	5	5	3	1,897	2.5	Yes	8	8	1	Yes	2	0.6	Yes
40	Vanderbilt University Medical Center, Nashville, Tenn.	61.7	5	5	4	2,419	2.4	Yes	8	8	1	Yes	2	2.2	Yes
41	AdventHealth Orlando	61.6	5	5	4	4,200	1.5	Yes	8	8	0	No	2	0.1	Yes
42	Fox Chase Cancer Center, Philadelphia	61.3	5	5	4	1,114	2.8	Yes	8	8	1	Yes	2	1.1	Yes
43	Lenox Hill Hospital at Northwell Health, New York	61.2	5	5	3	859	3.7	Yes	8	8	1	No	0	0.3	Yes
44	University of Kentucky Albert B. Chandler Hospital, Lexington	60.5	5	5	4	1,355	1.6	Yes	8	8	1	Yes	2	0.8	Yes
45	Emory University Hospital, Atlanta	60.1	5	5	5	2,314	2.4	Yes	8	8	1	Yes	2	1.5	Yes
46	Presbyterian-St. Luke's Medical Center, Denver	60.0	5	5	4	966	1.8	Yes	6	8	0	No	2	0.0	Yes
47	Thomas Jefferson University Hospitals-Sidney Kimmel Cancer Center, Philadelphia	59.8	5	5	4	1,838	2.1	Yes	8	8	1	Yes	2	0.8	Yes
47	UNC Hospitals, Chapel Hill, N.C.	59.8	5	5	4	1,904	1.7	Yes	8	8	1	Yes	2	2.3	Yes
47	University of Kansas Hospital, Kansas City	59.8	5	5	5	2,430	2.1	Yes	8	8	1	Yes	2	0.4	Yes
50	Smilow Cancer Hospital at Yale New Haven, Conn.	59.7	5	5	3	2,941	2.1	Yes	8	8	1	Yes	2	2.0	Yes

Best Hospitals 2023-24: Cardiology, Heart & Vascular Surgery

Rank	Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Public transparency	STS transparency	ACC transparency	Advanced technologies	Patient services	Trauma center	Recognized as Nurse Magnet hospital	Expert opinion	Current AHA responder
1	Cleveland Clinic	100.0	5	5	4	18,005	2.3	Yes	3	Yes	Yes	6	8	No	1	26.6	Yes
2	Cedars-Sinai Medical Center, Los Angeles	96.8	5	5	4	11,503	2.9	Yes	3	Yes	Yes	6	8	Yes	1	7.3	Yes
3	Mayo Clinic, Rochester, Minn.	95.1	5	5	5	12,900	3.1	Yes	3	Yes	Yes	6	8	Yes	1	24.6	Yes
4	Mount Sinai Hospital, New York	93.6	5	5	3	14,892	2.4	Yes	3	Yes	Yes	6	8	Yes	1	3.9	Yes
5	NYU Langone Hospitals, New York	91.9	5	5	4	18,872	2.3	Yes	3	Yes	Yes	6	8	Yes	1	4.5	Yes
6	New York-Presbyterian Hospital-Columbia and Cornell	89.4	5	5	4	20,319	3.0	Yes	3	Yes	Yes	6	8	Yes	1	9.4	Yes
7	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	85.1	5	5	4	7,019	2.0	Yes	3	Yes	Yes	6	8	Yes	1	3.9	Yes
8	Massachusetts General Hospital, Boston	84.7	5	5	5	10,898	2.6	Yes	3	Yes	Yes	6	8	Yes	1	10.7	Yes
9	Stanford Health Care-Stanford Hospital, Stanford, Calif.	83.5	5	5	5	5,552	3.7	Yes	3	Yes	Yes	6	8	Yes	1	4.5	Yes
10	Lenox Hill Hospital at Northwell Health, New York	82.8	5	5	3	7,182	3.7	Yes	3	Yes	Yes	5	8	No	1	1.0	Yes
11	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	80.4	5	5	4	11,748	2.8	Yes	3	Yes	Yes	6	8	Yes	1	5.8	Yes
12	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	78.0	5	5	3	12,655	2.9	Yes	3	Yes	Yes	6	8	Yes	1	1.0	Yes
13	Johns Hopkins Hospital, Baltimore	76.0	5	5	5	4,225	2.7	Yes	3	Yes	Yes	6	8	Yes	1	6.5	Yes
14	Houston Methodist Hospital	74.9	5	5	4	9,896	2.1	Yes	3	Yes	Yes	6	8	No	1	2.6	Yes
15	Rush University Medical Center, Chicago	74.8	5	5	4	3,830	1.8	Yes	3	Yes	Yes	6	8	Yes	1	0.9	Yes
16	Mount Sinai Morningside and Mount Sinai West Hospitals, New York	74.1	5	5	3	5,288	2.0	Yes	3	Yes	Yes	5	8	Yes	0	0.6	Yes
17	Texas Heart Institute at Baylor St. Luke's Medical Center, Houston	73.4	5	5	4	7,896	1.8	Yes	3	Yes	Yes	6	8	No	1	2.7	Yes
18	Brigham and Women's Hospital, Boston	73.2	5	5	4	8,057	2.3	Yes	3	Yes	Yes	6	8	Yes	1	8.2	Yes
18	UCLA Medical Center, Los Angeles	73.2	5	5	5	4,791	3.1	Yes	3	Yes	Yes	6	8	Yes	1	4.0	Yes
20	UT Southwestern Medical Center, Dallas	72.8	5	5	5	4,452	2.4	Yes	3	Yes	Yes	6	8	No	1	2.3	Yes
21	Vanderbilt University Medical Center, Nashville, Tenn.	71.4	5	5	4	8,182	2.4	Yes	3	Yes	Yes	6	8	Yes	1	3.6	Yes
22	University of Michigan Health Frankel Cardiovascular Center, Ann Arbor	68.9	5	5	5	7,801	2.7	Yes	3	Yes	Yes	6	8	Yes	1	3.4	Yes
23	UC San Diego Health-Cardiovascular Institute	67.9	5	5	4	4,373	2.2	Yes	3	Yes	Yes	6	8	Yes	1	0.9	Yes
24	Scripps La Jolla Hospitals, La Jolla, Calif.	66.7	5	5	4	8,782	2.7	Yes	3	Yes	Yes	5	8	Yes	1	0.9	Yes
25	Beaumont Hospital-Royal Oak, Mich.	66.6	5	5	3	10,777	1.7	Yes	3	Yes	Yes	5	8	Yes	1	0.8	Yes
26	St. Francis Hospital and Heart Center, Roslyn, N.Y.	66.4	5	5	5	13,508	1.8	Yes	3	Yes	Yes	5	8	No	1	0.7	Yes
27	UC Davis Medical Center, Sacramento, Calif.	66.3	5	5	4	3,781	2.8	Yes	3	Yes	Yes	5	8	Yes	1	0.6	Yes
28	Duke University Hospital, Durham, N.C.	65.9	5	5	5	8,305	2.2	Yes	3	Yes	Yes	6	8	Yes	1	6.5	Yes
29	Mayo Clinic-Jacksonville, Fla.	65.7	5	5	5	3,289	2.6	Yes	3	Yes	Yes	6	8	No	1	2.3	Yes
30	Advocate Christ Medical Center, Oak Lawn, Ill.	65.2	5	5	3	9,004	2.5	Yes	3	Yes	Yes	6	8	Yes	1	0.2	Yes
31	Montefiore Medical Center, Bronx, N.Y.	64.6	5	5	3	12,669	2.0	Yes	3	Yes	Yes	6	8	Yes	0	0.9	Yes
32	UCSF Health-UCSF Medical Center, San Francisco, Calif.	64.3	5	5	4	3,157	2.4	Yes	3	Yes	Yes	6	8	No	1	2.6	Yes
33	Mayo Clinic-Phoenix	63.9	5	5	5	3,744	2.3	Yes	3	Yes	Yes	6	8	No	1	2.6	Yes
33	MedStar Heart & Vascular Institute at MedStar Washington Hosp. Ctr., Washington, D.C.	63.9	5	5	2	11,280	2.4	Yes	3	Yes	Yes	6	8	Yes	0	1.5	Yes
35	Barnes-Jewish Hospital, Saint Louis	63.7	5	5	4	7,497	2.0	Yes	3	Yes	Yes	6	8	Yes	1	3.1	Yes
36	New York-Presbyterian Brooklyn Methodist Hospital, Brooklyn	63.6	5	5	3	4,692	1.2	Yes	3	Yes	Yes	5	8	Yes	0	0.1	Yes
36	Ohio State University Wexner Medical Center, Columbus	63.6	5	5	4	8,141	2.1	Yes	3	Yes	Yes	6	8	Yes	1	1.5	Yes
38	University of Chicago Medical Center	63.0	5	5	4	4,892	2.4	Yes	3	Yes	Yes	6	8	Yes	1	1.4	Yes
39	University of Alabama at Birmingham Hospital	62.9	5	5	4	7,794	2.3	Yes	3	Yes	Yes	6	8	Yes	1	1.8	Yes
40	Baylor Scott and White The Heart Hospital Plano, Texas	62.5	5	5	5	7,769	2.7	Yes	3	Yes	Yes	5	8	No	1	0.9	Yes
41	Keck Medical Center of USC, Los Angeles	62.4	5	5	4	2,334	2.6	Yes	3	Yes	Yes	6	8	No	1	1.0	Yes
42	Hackensack Univ. Medical Ctr. at Hackensack Meridian Health, Hackensack, N.J.	62.3	5	5	3	6,295	2.4	Yes	3	Yes	Yes	5	8	Yes	1	0.4	Yes
43	Aurora St. Luke's Medical Center, Milwaukee	61.9	5	5	4	11,127	2.3	Yes	3	Yes	Yes	6	8	No	1	0.3	Yes
44	Morristown Medical Center, Morristown, N.J.	61.5	5	5	4	11,524	1.9	Yes	3	Yes	Yes	5	8	Yes	1	0.8	Yes
45	Beth Israel Deaconess Medical Center, Boston	60.1	5	5	4	7,682	1.4	Yes	3	Yes	Yes	5	8	Yes	1	1.2	Yes
46	Virginia Mason Medical Center, Seattle	59.9	5	5	4	3,189	2.8	Yes	3	Yes	Yes	5	8	No	0	0.0	No
47	Saint Luke's Mid America Heart Institute, Kansas City, Mo.	59.5	5	5	5	5,993	1.7	Yes	3	Yes	Yes	6	8	Yes	1	0.9	Yes
48	UPMC Presbyterian Shadyside, Pittsburgh	59.3	5	5	4	8,253	2.4	Yes	3	Yes	Yes	6	8	Yes	1	2.4	Yes
49	Orlando Health-Orlando Regional Medical Center	59.1	5	5	3	13,747	2.0	Yes	3	Yes	Yes	5	8	Yes	1	0.1	Yes
49	University of Kansas Hospital, Kansas City	59.1	5	5	5	7,242	2.1	Yes	3	Yes	Yes	6	8	Yes	1	0.4	Yes

Rank	Best Hospitals 2023-24: Diabetes & Endocrinology	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Recognized as Nurse Magnet hospital	Expert opinion	Current AHA responder
1	Mayo Clinic, Rochester, Minn.	100.0	5	5	5	1,186	3.1	Yes	4	8	1	25.1	Yes
2	NYU Langone Hospitals, New York	90.8	5	5	4	2,075	2.3	Yes	4	8	1	3.7	Yes
3	New York-Presbyterian Hospital-Columbia and Cornell	86.1	5	5	4	2,398	3.0	Yes	4	8	1	6.2	Yes
4	Houston Methodist Hospital	85.4	5	5	4	1,020	2.1	Yes	4	8	1	1.2	Yes
5	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	84.9	5	5	4	735	2.0	Yes	4	8	1	1.8	Yes
6	UCLA Medical Center, Los Angeles	84.7	5	5	5	916	3.1	Yes	4	8	1	4.5	Yes
7	Cedars-Sinai Medical Center, Los Angeles	83.6	5	5	4	978	2.9	Yes	4	8	1	2.4	Yes
7	Massachusetts General Hospital, Boston	83.6	5	5	5	1,072	2.6	Yes	4	8	1	17.3	Yes
9	Stanford Health Care-Stanford Hospital, Stanford, Calif.	83.1	5	5	5	594	3.7	Yes	4	8	1	1.1	Yes
10	Mayo Clinic-Phoenix	79.5	5	5	5	501	2.3	Yes	4	8	1	1.7	Yes
11	Brigham and Women's Hospital, Boston	78.7	5	5	4	746	2.3	Yes	4	8	1	8.2	Yes
12	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	77.6	5	5	3	1,122	2.9	Yes	4	8	1	0.8	Yes
13	NorthShore University Health System-Metro Chicago	76.6	5	5	4	1,329	1.3	Yes	4	8	1	0.0	Yes
13	UCSF Health-UCSF Medical Center, San Francisco, Calif.	76.6	5	5	4	646	2.4	Yes	4	8	1	7.3	Yes
15	Barnes-Jewish Hospital, Saint Louis	75.1	5	5	4	927	2.0	Yes	4	8	1	5.9	Yes
16	Mayo Clinic-Jacksonville, Fla.	74.1	5	5	5	563	2.6	Yes	4	8	1	1.7	Yes
17	UT Southwestern Medical Center, Dallas	73.9	5	5	5	673	2.4	Yes	4	8	1	1.6	Yes
18	Tampa General Hospital	71.9	5	5	3	1,343	2.4	Yes	4	8	1	0.5	Yes
19	Long Island Jewish Medical Center at Northwell Health, New Hyde Park, N.Y.	71.1	5	5	3	2,021	1.9	Yes	4	8	1	0.6	Yes
20	Ohio State University Wexner Medical Center, Columbus	71.0	5	5	4	1,009	2.1	Yes	4	8	1	2.1	Yes
21	Mount Sinai Hospital, New York	70.8	5	5	3	1,024	2.4	Yes	4	8	1	3.1	Yes
22	Beaumont Hospital-Royal Oak, Mich.	69.8	5	5	3	1,117	1.7	Yes	4	8	1	0.1	Yes
23	University of Chicago Medical Center	69.6	5	5	4	748	2.4	Yes	4	8	1	2.4	Yes
24	Cleveland Clinic	69.4	5	5	4	849	2.3	Yes	4	8	1	6.1	Yes
25	UPMC Presbyterian Shadyside, Pittsburgh	69.2	5	5	4	1,072	2.4	Yes	4	8	1	1.9	Yes
26	UCHealth University of Colorado Hospital, Aurora	68.7	5	5	4	662	2.1	Yes	4	8	1	6.3	Yes
27	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	68.6	5	5	4	814	2.8	Yes	4	8	1	4.2	Yes
27	Johns Hopkins Hospital, Baltimore	68.6	5	5	5	490	2.7	Yes	4	8	1	7.6	Yes
29	Baylor Scott and White All Saints Medical Center-Fort Worth	68.2	5	5	4	414	2.2	Yes	4	8	1	0.0	Yes
30	UW Medicine-University of Washington Medical Center, Seattle	67.6	5	5	4	508	2.1	Yes	4	8	1	3.2	Yes
31	Montefiore Medical Center, Bronx, N.Y.	67.4	5	5	3	2,194	2.0	Yes	4	8	0	1.6	Yes
32	Baylor St. Luke's Medical Center, Houston	67.2	5	5	4	540	1.8	Yes	4	8	1	0.6	Yes
33	AdventHealth Orlando	66.8	5	5	4	3,298	1.5	Yes	4	8	0	0.2	Yes
33	New York-Presbyterian Brooklyn Methodist Hospital, Brooklyn	66.8	5	5	3	1,082	1.2	Yes	4	8	0	0.0	Yes
33	UC Davis Medical Center, Sacramento, Calif.	66.8	5	5	4	463	2.8	Yes	4	8	1	0.1	Yes
36	Lenox Hill Hospital at Northwell Health, New York	66.7	5	4	3	609	3.7	Yes	4	8	1	0.8	Yes
37	John Muir Health-Walnut Creek Medical Center, Walnut Creek, Calif.	66.4	5	5	4	451	2.5	Yes	4	8	1	0.0	Yes
38	Rush University Medical Center, Chicago	66.3	5	5	4	634	1.8	Yes	4	8	1	0.4	Yes
39	Lancaster General Hospital, Lancaster, Pa.	66.2	5	5	4	869	1.6	Yes	4	8	1	0.0	Yes
39	UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego	66.2	5	5	4	381	2.2	Yes	4	8	1	0.7	Yes
41	Torrance Memorial Medical Center, Torrance, Calif.	65.7	5	5	5	748	2.5	Yes	4	8	1	0.1	Yes
42	University of Michigan Health-Ann Arbor	65.5	5	3	5	694	2.7	Yes	4	8	1	4.8	Yes
43	St. Francis Hospital and Heart Center, Roslyn, N.Y.	64.9	5	5	5	413	1.8	Yes	4	8	1	0.0	Yes
44	University of Alabama at Birmingham Hospital	64.3	5	5	4	605	2.3	Yes	4	8	1	0.8	Yes
45	Yale New Haven Hospital, New Haven, Conn.	64.0	5	3	3	1,357	2.1	Yes	4	8	1	3.4	Yes
46	Plainview Hospital at Northwell Health, Plainview, N.Y.	63.9	5	5	3	360	1.9	Yes	4	8	1	0.0	Yes
46	Vanderbilt University Medical Center, Nashville, Tenn.	63.9	4	5	4	763	2.4	Yes	4	8	1	3.1	Yes
48	Brigham and Women's Faulkner Hospital, Boston	63.8	5	5	4	378	1.0	Yes	4	7	1	0.4	Yes
49	Queen's Medical Center, Honolulu	63.4	5	5	4	885	1.5	Yes	4	8	1	0.0	Yes
50	UCI Medical Center, Orange, Calif.	63.0	5	5	4	538	2.0	Yes	4	8	1	1.0	Yes

Rank	Best Hospitals 2023-24: Ear, Nose & Throat Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Trauma center	Recognized as Nurse Magnet hospital	Expert opinion	Current AHA responder
1	Stanford Health Care-Stanford Hospital, Stanford, Calif.	100.0	5	5	5	1,060	3.7	Yes	1	8	Yes	1	7.9	Yes
2	University of Texas MD Anderson Cancer Center, Houston	87.5	5	5	5	2,139	2.0	Yes	1	8	No	1	4.4	Yes
3	UCLA Medical Center, Los Angeles	86.1	5	5	5	1,526	3.1	Yes	1	8	Yes	1	5.9	Yes
4	Mayo Clinic, Rochester, Minn.	85.3	4	5	5	1,925	3.1	Yes	1	8	Yes	1	8.9	Yes
5	Vanderbilt University Medical Center, Nashville, Tenn.	83.0	5	5	4	1,647	2.4	Yes	1	8	Yes	1	8.6	Yes
6	Memorial Sloan Kettering Cancer Center, New York	82.2	5	5	5	787	2.5	Yes	1	8	No	1	1.4	Yes
7	Mass Eye and Ear, Massachusetts General Hospital, Boston	80.5	5	2	5	2,024	2.6	Yes	1	8	Yes	1	11.2	Yes
8	Johns Hopkins Hospital, Baltimore	78.7	5	5	5	895	2.7	Yes	1	8	Yes	1	11.9	Yes
9	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	78.1	5	2	4	1,648	2.8	Yes	1	8	Yes	1	7.4	Yes
10	Barnes-Jewish Hospital, Saint Louis	77.6	5	5	4	1,364	2.0	Yes	1	8	Yes	1	4.5	Yes
11	NYU Langone Hospitals, New York	74.7	5	5	4	811	2.3	Yes	1	8	Yes	1	3.1	Yes
12	OHSU Hospital, Portland, Ore.	73.6	5	3	4	1,088	2.2	Yes	1	8	Yes	1	2.1	Yes
12	University of Michigan Health-Ann Arbor	73.6	4	2	5	1,540	2.7	Yes	1	8	Yes	1	8.4	Yes
14	UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego	71.3	5	3	4	624	2.2	Yes	1	8	Yes	1	2.1	Yes
15	New York-Presbyterian Hospital-Columbia and Cornell	71.0	4	4	4	1,310	3.0	Yes	1	8	Yes	1	3.3	Yes
15	University of Alabama at Birmingham Hospital	71.0	4	5	4	1,692	2.3	Yes	1	8	Yes	1	2.7	Yes
17	Mayo Clinic-Phoenix	70.2	5	5	5	733	2.3	Yes	1	8	No	1	1.5	Yes
18	UC Davis Medical Center, Sacramento, Calif.	70.0	5	4	4	880	2.8	Yes	1	8	Yes	1	2.4	Yes
19	Cedars-Sinai Medical Center, Los Angeles	69.6	4	5	4	641	2.9	Yes	1	8	Yes	1	1.4	Yes
20	UCSF Health-UCSF Medical Center, San Francisco, Calif.	68.2	5	4	4	1,139	2.4	Yes	1	8	No	1	5.9	Yes
21	Brigham and Women's Hospital, Boston	67.7	5	3	4	726	2.3	Yes	1	8	Yes	1	2.2	Yes
22	Rush University Medical Center, Chicago	66.7	5	5	4	732	1.8	Yes	1	8	Yes	1	0.9	Yes
23	MUSC Health-University Medical Center, Charleston, S.C.	66.6	4	5	4	1,445	1.8	Yes	1	8	Yes	1	4.1	Yes
23	University of Maryland Medical Center, Baltimore	66.6	5	4	4	786	2.4	Yes	1	8	Yes	1	1.0	Yes
25	Cleveland Clinic	65.6	4	3	4	1,447	2.3	Yes	1	8	No	1	6.8	Yes
26	UT Southwestern Medical Center, Dallas	64.9	5	5	5	858	2.4	Yes	1	8	No	1	1.4	Yes
27	Jefferson Health-Thomas Jefferson University Hospitals, Philadelphia	64.7	3	3	4	1,582	2.1	Yes	1	8	Yes	1	3.6	Yes
28	University of Iowa Hospitals and Clinics, Iowa City	63.0	4	5	4	799	1.7	Yes	1	8	Yes	1	6.5	Yes
29	Long Island Jewish Medical Center at Northwell Health, New Hyde Park, N.Y.	62.9	4	5	3	1,376	1.9	Yes	1	8	Yes	1	1.2	Yes
30	Manhattan Eye, Ear & Throat Hospital, New York	62.6	4	3	3	527	3.7	Yes	1	8	No	1	1.2	Yes
30	UF Health Shands Hospital, Gainesville, Fla.	62.6	5	1	4	1,280	2.0	Yes	1	8	Yes	1	1.4	Yes
32	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	62.2	4	5	4	608	2.0	Yes	1	8	Yes	1	2.7	Yes
32	University of Chicago Medical Center	62.2	4	5	4	753	2.4	Yes	1	8	Yes	1	1.2	Yes
34	University of Kansas Hospital, Kansas City	61.4	4	3	5	1,236	2.1	Yes	1	8	Yes	1	2.3	Yes
35	Ohio State University Wexner Medical Center, Columbus	61.1	3	5	4	1,686	2.1	Yes	1	8	Yes	1	6.5	Yes
36	Mount Sinai Hospital, New York	60.7	3	5	3	1,100	2.4	Yes	1	8	Yes	1	3.3	Yes
37	Emory University Hospital Midtown, Atlanta	59.7	5	5	3	1,195	1.7	Yes	1	8	No	0	1.9	Yes
38	Yale New Haven Hospital, New Haven, Conn.	59.1	4	3	3	1,206	2.1	Yes	1	8	Yes	1	0.8	Yes
39	Tampa General Hospital	59.0	3	5	3	758	2.4	Yes	1	8	Yes	1	0.7	Yes
40	M Health Fairview University of Minnesota Medical Center, Minneapolis	58.7	5	3	4	322	2.0	Yes	1	8	Yes	0	1.9	Yes
41	UNC Hospitals, Chapel Hill, N.C.	58.3	3	5	4	1,364	1.7	Yes	1	8	Yes	1	3.1	Yes
42	Ochsner Medical Center, New Orleans	57.9	4	5	4	683	1.7	Yes	1	8	No	1	1.2	Yes
43	Baylor Scott and White All Saints Medical Center-Fort Worth	57.6	4	3	4	763	2.2	Yes	1	8	No	1	0.0	Yes
44	UPMC Presbyterian Shadyside, Pittsburgh	56.9	3	3	4	1,268	2.4	Yes	1	8	Yes	1	5.9	Yes
44	UW Health University Hospital, Madison, Wis.	56.9	3	5	4	1,055	2.2	Yes	1	8	Yes	1	0.9	Yes
46	Morristown Medical Center, Morristown, N.J.	56.5	4	3	4	554	1.9	Yes	1	8	Yes	1	0.1	Yes
47	Beaumont Hospital-Royal Oak, Mich.	54.5	4	4	3	559	1.7	Yes	1	8	Yes	1	0.1	Yes
48	Keck Medical Center of USC, Los Angeles	54.4	3	5	4	579	2.6	Yes	1	8	No	1	2.8	Yes
49	Nebraska Medicine-Nebraska Medical Center, Omaha	54.3	4	3	4	361	2.1	Yes	1	8	Yes	1	0.4	Yes
49	University of Kentucky Albert B. Chandler Hospital, Lexington	54.3	3	5	4	829	1.6	Yes	1	8	Yes	1	1.3	Yes

Rank	Best Hospitals 2023-24: Gastroenterology & GI Surgery Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Trauma center	Recognized as Nurse Magnet hospital	Expert opinion	Current AHA responder
1	Mayo Clinic, Rochester, Minn.	100.0	5	5	5	8,034	3.1	Yes	7	8	Yes	1	23.5	Yes
2	Cedars-Sinai Medical Center, Los Angeles	92.3	5	5	4	6,019	2.9	Yes	7	8	Yes	1	4.8	Yes
3	UCLA Medical Center, Los Angeles	90.1	5	5	5	3,631	3.1	Yes	7	8	Yes	1	6.0	Yes
4	NYU Langone Hospitals, New York	87.6	5	5	4	9,997	2.3	Yes	7	8	Yes	1	4.7	Yes
5	Houston Methodist Hospital	87.5	5	5	4	6,056	2.1	Yes	7	8	No	1	1.9	Yes
6	Mount Sinai Hospital, New York	87.3	5	5	3	4,880	2.4	Yes	7	8	Yes	1	6.5	Yes
7	New York-Presbyterian Hospital-Columbia and Cornell	85.9	5	5	4	10,314	3.0	Yes	7	8	Yes	1	5.3	Yes
8	Cleveland Clinic	85.8	5	5	4	6,803	2.3	Yes	7	8	No	1	13.7	Yes
9	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	83.9	5	5	4	3,980	2.0	Yes	7	8	Yes	1	5.4	Yes
10	Stanford Health Care-Stanford Hospital, Stanford, Calif.	82.8	5	5	5	3,900	3.7	Yes	7	8	Yes	1	2.3	Yes
11	Hosps. of the Univ. of Pennsylvania-Penn Presbyterian, Philadelphia	82.4	5	5	4	4,714	2.8	Yes	7	8	Yes	1	4.4	Yes
12	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	81.2	5	5	3	5,234	2.9	Yes	7	8	Yes	1	0.8	Yes
13	Keck Medical Center of USC, Los Angeles	81.0	5	5	4	1,740	2.6	Yes	7	8	No	1	1.7	Yes
14	Johns Hopkins Hospital, Baltimore	80.8	5	5	5	3,054	2.7	Yes	7	8	Yes	1	7.1	Yes
15	Mayo Clinic-Phoenix	80.5	5	5	5	3,115	2.3	Yes	7	8	No	1	4.6	Yes
16	Memorial Sloan Kettering Cancer Center, New York	80.4	5	5	5	5,148	2.5	Yes	6	8	No	1	1.9	Yes
17	Massachusetts General Hospital, Boston	80.0	5	5	5	5,968	2.6	Yes	7	8	Yes	1	7.6	Yes
18	UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego	79.1	5	5	4	2,879	2.2	Yes	7	8	Yes	1	2.1	Yes
19	Tampa General Hospital	77.3	5	5	3	3,605	2.4	Yes	7	8	Yes	1	0.7	Yes
19	University of Texas MD Anderson Cancer Center, Houston	77.3	5	5	5	4,601	2.0	Yes	6	8	No	1	1.8	Yes
21	Brigham and Women's Hospital, Boston	77.1	5	5	4	5,084	2.3	Yes	6	8	Yes	1	4.2	Yes
22	University of Chicago Medical Center	76.6	5	5	4	3,284	2.4	Yes	7	8	Yes	1	4.0	Yes
23	Rush University Medical Center, Chicago	76.3	5	5	4	2,329	1.8	Yes	7	8	Yes	1	1.3	Yes
24	Beth Israel Deaconess Medical Center, Boston	76.1	5	5	4	4,244	1.4	Yes	7	8	Yes	1	2.1	Yes
24	Mayo Clinic-Jacksonville, Fla.	76.1	5	5	5	3,167	2.6	Yes	7	8	No	1	4.0	Yes
24	St. Francis Hospital and Heart Center, Roslyn, N.Y.	76.1	5	5	5	3,448	1.8	Yes	6	8	No	1	0.2	Yes
27	UPMC Presbyterian Shadyside, Pittsburgh	76.0	5	5	4	6,400	2.4	Yes	7	8	Yes	1	3.1	Yes
28	University of Michigan Health-Ann Arbor	75.6	5	5	5	4,427	2.7	Yes	7	8	Yes	1	5.2	Yes
29	Barnes-Jewish Hospital, Saint Louis	75.1	5	5	4	5,902	2.0	Yes	7	8	Yes	1	4.1	Yes
29	UCSF Health-UCSF Medical Center, San Francisco, Calif.	75.1	5	5	4	2,839	2.4	Yes	7	8	No	1	5.0	Yes
31	Jefferson Health-Thomas Jefferson University Hospitals, Philadelphia	74.8	5	5	4	4,087	2.1	Yes	7	8	Yes	1	1.8	Yes
32	Beaumont Hospital-Royal Oak, Mich.	74.3	5	5	3	5,354	1.7	Yes	7	8	Yes	1	0.2	Yes
33	Baylor University Medical Center, Dallas	74.0	5	5	4	4,294	2.0	Yes	7	8	Yes	1	1.3	Yes
34	Duke University Hospital, Durham, N.C.	73.7	5	5	5	4,126	2.2	Yes	7	8	Yes	1	3.4	Yes
35	UT Southwestern Medical Center, Dallas	73.5	5	5	5	2,883	2.4	Yes	7	8	No	1	1.9	Yes
36	OHSU Hospital, Portland, Ore.	72.6	5	5	4	2,383	2.2	Yes	7	8	Yes	1	0.5	Yes
37	Scripps La Jolla Hospitals, La Jolla, Calif.	72.1	5	5	4	3,998	2.7	Yes	7	8	Yes	1	0.4	Yes
38	Baylor St. Luke's Medical Center, Houston	71.6	5	5	4	3,064	1.8	Yes	7	8	No	1	1.7	Yes
39	Cleveland Clinic Weston, Fla.	70.6	5	5	4	2,815	2.1	Yes	7	8	No	0	1.6	Yes
40	Long Island Jewish Med. Ctr. at Northwell Health, New Hyde Park, N.Y.	69.8	5	5	3	5,954	1.9	Yes	6	8	Yes	1	0.5	Yes
41	Advocate Good Shepherd Hospital, Barrington, Ill.	69.4	5	5	4	1,572	2.0	Yes	6	8	Yes	1	0.0	Yes
42	Yale New Haven Hospital, New Haven, Conn.	69.0	5	5	3	5,761	2.1	Yes	7	8	Yes	1	1.9	Yes
43	Vanderbilt University Medical Center, Nashville, Tenn.	68.4	5	5	4	4,187	2.4	Yes	7	8	Yes	1	1.8	Yes
44	University of Kansas Hospital, Kansas City	68.3	5	5	5	3,972	2.1	Yes	7	8	Yes	1	0.2	Yes
45	Ohio State University Wexner Medical Center, Columbus	67.5	5	5	4	6,255	2.1	Yes	7	8	Yes	1	2.5	Yes
46	Cleveland Clinic Hillcrest Hospital, Mayfield Heights, Ohio	67.4	5	5	3	3,620	1.5	Yes	6	8	Yes	1	0.3	Yes
47	Beaumont Hospital-Troy, Mich.	67.3	5	5	4	4,858	1.6	Yes	6	8	Yes	1	0.1	Yes
48	NorthShore University Health System-Metro Chicago	67.0	5	5	4	5,299	1.3	Yes	6	8	Yes	1	0.3	Yes
49	Queen's Medical Center, Honolulu	66.9	5	5	4	3,332	1.5	Yes	7	8	Yes	1	0.1	Yes
50	University of Alabama at Birmingham Hospital	66.7	5	5	4	3,524	2.3	Yes	7	8	Yes	1	1.5	Yes

Rank	Best Hospitals 2023-24: Geriatrics Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Patient services	Recognized as Nurse Magnet hospital	NIA-designated Alzheimer's center	Expert opinion	Current AHA responder
1	Mount Sinai Hospital, New York	100.0	5	5	3	27,593	2.4	Yes	9	1	Yes	16.1	Yes
2	NYU Langone Hospitals, New York	94.3	5	5	4	58,631	2.3	Yes	9	1	Yes	2.3	Yes
3	UCLA Medical Center, Los Angeles	92.2	5	5	5	17,667	3.1	Yes	9	1	No	18.0	Yes
4	UCSF Health-UCSF Medical Center, San Francisco, Calif.	91.6	5	5	4	11,548	2.4	Yes	9	1	Yes	10.3	Yes
5	Mayo Clinic, Rochester, Minn.	91.0	5	5	5	30,955	3.1	Yes	9	1	Yes	7.4	Yes
6	Cleveland Clinic	90.3	5	5	4	23,717	2.3	Yes	9	1	Yes	5.7	Yes
7	New York-Presbyterian Hospital-Columbia and Cornell	86.6	5	5	4	63,671	3.0	Yes	9	1	Yes	3.4	Yes
8	Cedars-Sinai Medical Center, Los Angeles	84.9	5	5	4	33,004	2.9	Yes	7	1	No	1.1	Yes
9	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	83.3	5	5	4	16,775	2.0	Yes	9	1	Yes	1.0	Yes
10	Stanford Health Care-Stanford Hospital, Stanford, Calif.	83.1	5	5	5	16,032	3.7	Yes	9	1	Yes	1.0	Yes
11	Hosps. of the Univ. of Pennsylvania-Penn Presbyterian, Philadelphia	82.5	5	5	4	19,793	2.8	Yes	9	1	Yes	2.3	Yes
12	Massachusetts General Hospital, Boston	81.7	5	5	5	27,955	2.6	Yes	9	1	Yes	4.8	Yes
12	Rush University Medical Center, Chicago	81.7	5	5	4	11,054	1.8	Yes	9	1	Yes	1.5	Yes
14	Johns Hopkins Hospital, Baltimore	81.3	5	5	5	10,237	2.7	Yes	9	1	Yes	7.5	Yes
15	Houston Methodist Hospital	80.8	5	5	4	24,853	2.1	Yes	9	1	No	1.4	Yes
16	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	79.8	5	5	3	38,182	2.9	Yes	9	1	No	1.2	Yes
17	UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego	78.1	5	5	4	11,477	2.2	Yes	9	1	Yes	2.6	Yes
18	Lenox Hill Hospital at Northwell Health, New York	76.8	5	5	3	18,248	3.7	Yes	9	1	No	0.9	Yes
19	Mayo Clinic-Phoenix	75.3	5	5	5	11,972	2.3	Yes	8	1	Yes	1.6	Yes
20	UT Southwestern Medical Center, Dallas	74.6	5	5	5	12,048	2.4	Yes	9	1	No	0.9	Yes
21	University of Michigan Health-Ann Arbor	73.7	5	5	5	15,669	2.7	Yes	9	1	Yes	3.9	Yes
22	Keck Medical Center of USC, Los Angeles	73.1	5	5	4	5,246	2.6	Yes	9	1	Yes	1.0	Yes
23	St. Francis Hospital and Heart Center, Roslyn, N.Y.	72.6	5	5	5	25,120	1.8	Yes	8	1	No	0.1	Yes
24	Brigham and Women's Hospital, Boston	71.4	5	5	4	20,380	2.3	Yes	9	1	Yes	1.4	Yes
25	Barnes-Jewish Hospital, Saint Louis	71.1	5	5	4	19,853	2.0	Yes	9	1	Yes	0.9	Yes
26	Yale New Haven Hospital, New Haven, Conn.	69.8	5	5	3	33,745	2.1	Yes	9	1	Yes	3.2	Yes
27	Mayo Clinic-Jacksonville, Fla.	69.6	5	5	5	10,507	2.6	Yes	8	1	Yes	1.3	Yes
28	Duke University Hospital, Durham, N.C.	69.4	5	5	5	16,874	2.2	Yes	9	1	Yes	5.3	Yes
29	Long Island Jewish Medical Ctr. at Northwell Health, New Hyde Park, N.Y.	69.3	5	5	3	38,993	1.9	Yes	9	1	No	1.5	Yes
30	UPMC Presbyterian Shadyside, Pittsburgh	68.9	5	5	4	21,699	2.4	Yes	9	1	Yes	3.4	Yes
31	Mount Sinai Morningside and Mount Sinai West Hospitals, New York	68.5	5	5	3	18,781	2.0	Yes	9	0	No	2.9	Yes
32	UC Davis Medical Center, Sacramento, Calif.	68.4	5	5	4	10,125	2.8	Yes	9	1	Yes	0.4	Yes
33	Huntington Hospital at Northwell Health, Huntington, N.Y.	67.6	5	5	4	16,434	2.2	Yes	9	1	No	0.3	Yes
34	Beaumont Hospital-Royal Oak, Mich.	67.3	5	5	3	31,306	1.7	Yes	9	1	No	0.2	Yes
34	University of Kansas Hospital, Kansas City	67.3	5	5	5	15,373	2.1	Yes	8	1	Yes	0.3	Yes
36	Hackensack Univ. Med. Ctr. at Hackensack Meridian Health, Hackensack, N.J.	66.1	5	5	3	19,597	2.4	Yes	9	1	No	1.5	Yes
37	Beaumont Hospital-Grosse Pointe, Mich.	65.8	5	5	4	7,684	1.5	Yes	9	1	No	0.0	Yes
38	Baylor St. Luke's Medical Center, Houston	65.6	5	5	4	11,349	1.8	Yes	7	1	No	0.7	Yes
39	Scripps La Jolla Hospitals, La Jolla, Calif.	65.1	5	5	4	22,597	2.7	Yes	7	1	No	0.1	Yes
40	Vanderbilt University Medical Center, Nashville, Tenn.	64.7	5	5	4	16,163	2.4	Yes	9	1	Yes	1.1	Yes
41	Emory University Hospital at Wesley Woods, Atlanta	64.5	5	5	5	11,757	2.4	Yes	9	1	Yes	0.5	Yes
42	UF Health Shands Hospital, Gainesville, Fla.	62.6	5	5	4	19,895	2.0	Yes	9	1	Yes	0.5	Yes
43	Northwestern Lake Forest Hospital, Lake Forest, Ill.	62.5	5	5	4	6,189	1.7	Yes	9	1	No	0.1	Yes
43	University of Chicago Medical Center	62.5	5	5	4	11,749	2.4	Yes	9	1	No	1.5	Yes
45	New York-Presbyterian Brooklyn Methodist Hospital, Brooklyn	62.4	5	5	3	17,958	1.2	Yes	9	0	No	0.0	Yes
46	Morristown Medical Center, Morristown, N.J.	62.1	5	5	4	28,154	1.9	Yes	9	1	No	1.5	Yes
47	Mount Sinai Beth Israel, New York	61.9	5	5	3	16,992	1.4	Yes	9	0	No	1.5	Yes
47	University of Alabama at Birmingham Hospital	61.9	5	5	4	15,955	2.3	Yes	9	1	Yes	2.5	Yes
49	Jefferson Health-Thomas Jefferson University Hospitals, Philadelphia	61.8	5	5	4	17,808	2.1	Yes	9	1	No	0.7	Yes
50	DMC Harper University Hospital, Detroit	61.4	5	5	1	3,804	1.0	Yes	8	0	Yes	0.1	Yes

Rank	Best Hospitals 2023-24: Neurology & Neurosurgery	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Trauma center	Recognized as Nurse Magnet hospital	NAEC-designated epilepsy center	NIA-designated Alzheimer's center	Public transparency	Expert opinion	Current AHA responder
1	NYU Langone Hospitals, New York	100.0	5	5	4	7,256	2.3	Yes	5	9	Yes	1	Yes	Yes	1	5.5	Yes
2	UCSF Health-UCSF Medical Center, San Francisco, Calif.	96.9	5	5	4	2,759	2.4	Yes	5	9	No	1	Yes	Yes	1	17.4	Yes
3	New York-Presbyterian Hospital-Columbia and Cornell	93.3	5	5	4	8,648	3.0	Yes	5	9	Yes	1	Yes	Yes	1	10.4	Yes
4	Mayo Clinic, Rochester, Minn.	91.0	5	5	5	4,806	3.1	Yes	5	9	Yes	1	Yes	Yes	1	20.1	Yes
5	Cedars-Sinai Medical Center, Los Angeles	88.4	5	5	4	3,733	2.9	Yes	5	8	Yes	1	Yes	No	1	1.8	Yes
6	UCLA Medical Center, Los Angeles	88.1	5	5	5	2,910	3.1	Yes	5	9	Yes	1	Yes	No	1	7.5	Yes
7	Johns Hopkins Hospital, Baltimore	85.5	5	5	5	2,729	2.7	Yes	5	9	Yes	1	Yes	Yes	1	14.9	Yes
8	Massachusetts General Hospital, Boston	84.5	5	5	5	5,016	2.6	Yes	5	9	Yes	1	Yes	Yes	1	14.0	Yes
9	Mount Sinai Hospital, New York	84.2	5	5	3	3,205	2.4	Yes	5	9	Yes	1	Yes	Yes	1	2.5	Yes
10	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	83.8	5	5	4	3,031	2.0	Yes	5	9	Yes	1	Yes	Yes	1	4.0	Yes
11	Houston Methodist Hospital	83.3	5	5	4	4,659	2.1	Yes	5	9	No	1	Yes	No	1	1.2	Yes
12	Stanford Health Care-Stanford Hospital, Stanford, Calif.	83.0	5	5	5	2,913	3.7	Yes	5	9	Yes	1	Yes	Yes	1	4.5	Yes
13	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	82.1	5	5	4	3,636	2.8	Yes	5	9	Yes	1	Yes	Yes	1	5.5	Yes
14	Rush University Medical Center, Chicago	81.4	5	5	4	2,580	1.8	Yes	5	9	Yes	1	Yes	Yes	1	3.5	Yes
15	Long Island Jewish Medical Center at Northwell Health, New Hyde Park, N.Y.	79.2	5	5	3	4,420	1.9	Yes	5	9	Yes	1	Yes	No	1	0.7	Yes
16	Cleveland Clinic	79.0	5	5	4	4,573	2.3	Yes	5	9	No	1	Yes	Yes	1	7.4	Yes
17	Barnes-Jewish Hospital, Saint Louis	78.8	5	5	4	5,057	2.0	Yes	5	9	Yes	1	Yes	Yes	1	5.0	Yes
18	UT Southwestern Medical Center, Dallas	76.5	5	5	5	2,811	2.4	Yes	5	9	No	1	Yes	No	1	2.0	Yes
19	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	76.2	5	5	3	4,656	2.9	Yes	5	9	Yes	1	Yes	No	1	0.7	Yes
20	University of Miami Hospital and Clinics-UHealth Tower	75.5	5	5	4	1,095	1.5	Yes	5	9	No	0	Yes	Yes	1	2.0	Yes
21	UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego	74.1	5	5	4	2,304	2.2	Yes	5	9	Yes	1	Yes	Yes	1	2.0	Yes
22	Hackensack University Medical Center at Hackensack Meridian Health, Hackensack, N.J.	73.1	5	5	3	2,889	2.4	Yes	5	9	Yes	1	Yes	No	1	0.3	Yes
23	Beaumont Hospital-Royal Oak, Mich.	71.6	5	5	3	4,119	1.7	Yes	5	9	Yes	1	Yes	No	1	0.0	Yes
24	Mayo Clinic-Jacksonville, Fla.	71.5	5	5	5	2,325	2.6	Yes	5	9	No	1	Yes	Yes	1	3.8	Yes
25	University of Kansas Hospital, Kansas City	71.4	5	5	5	3,910	2.1	Yes	5	9	Yes	1	Yes	Yes	1	0.7	Yes
26	Brigham and Women's Hospital, Boston	71.2	5	5	4	4,266	2.3	Yes	5	9	Yes	1	Yes	Yes	1	5.9	Yes
27	Mayo Clinic-Phoenix	70.8	5	5	5	1,666	2.3	Yes	5	9	No	1	Yes	Yes	1	3.7	Yes
28	Mount Sinai Morningside and Mount Sinai West Hospitals, New York	70.6	5	5	3	3,351	2.0	Yes	5	9	Yes	0	Yes	No	1	0.7	Yes
29	Duke University Hospital, Durham, N.C.	70.1	5	5	5	3,624	2.2	Yes	5	9	Yes	1	Yes	Yes	1	4.6	Yes
30	Memorial Hermann Hospital, Houston	70.0	5	5	4	5,783	2.4	Yes	5	9	Yes	1	Yes	No	1	1.2	Yes
30	UF Health Shands Hospital, Gainesville, Fla.	70.0	5	5	4	4,240	2.0	Yes	5	9	Yes	1	Yes	Yes	1	2.3	Yes
32	New York-Presbyterian Brooklyn Methodist Hospital, Brooklyn	69.9	5	5	3	2,115	1.2	Yes	5	9	Yes	0	No	No	1	0.1	Yes
32	UC Davis Medical Center, Sacramento, Calif.	69.9	5	5	4	2,031	2.8	Yes	5	9	Yes	1	Yes	Yes	1	0.6	Yes
34	Northwestern Lake Forest Hospital, Lake Forest, Ill.	69.5	5	5	4	747	1.7	Yes	5	9	Yes	1	No	No	1	0.2	Yes
35	AdventHealth Orlando	69.1	5	5	4	10,615	1.5	Yes	5	9	No	0	Yes	No	1	0.2	Yes
36	Baylor St. Luke's Medical Center, Houston	68.7	5	5	4	2,602	1.8	Yes	5	9	No	1	Yes	No	1	0.7	Yes
37	University of Michigan Health-Ann Arbor	68.4	4	5	5	2,654	2.7	Yes	5	9	Yes	1	Yes	Yes	1	3.1	Yes
38	Baylor University Medical Center, Dallas	68.3	5	5	4	3,823	2.0	Yes	5	8	Yes	1	Yes	No	1	0.4	Yes
39	Baptist Health Miami Neuroscience Institute at Baptist Hospital of Miami	67.7	5	5	3	3,298	1.4	Yes	5	8	No	1	Yes	No	1	1.0	Yes
40	Lenox Hill Hospital at Northwell Health, New York	67.6	5	5	3	1,916	3.7	Yes	5	9	No	1	Yes	No	1	0.7	Yes
40	Thomas Jefferson University Hospitals-Vickie and Jack Farber Institute for Neuroscience, Pl	67.6	5	5	4	4,672	2.1	Yes	5	9	Yes	1	Yes	No	1	1.8	Yes
42	NorthShore University Health System-Metro Chicago	67.5	5	5	4	4,107	1.3	Yes	5	9	Yes	1	No	No	1	0.2	Yes
43	UPMC Presbyterian Shadyside, Pittsburgh	67.4	3	5	4	6,030	2.4	Yes	5	9	Yes	1	Yes	Yes	1	2.1	Yes
44	Ohio State University Wexner Medical Center, Columbus	67.0	5	5	4	5,834	2.1	Yes	5	9	Yes	1	Yes	No	1	2.2	Yes
44	St. Francis Hospital and Heart Center, Roslyn, N.Y.	67.0	5	5	5	1,953	1.8	Yes	5	8	No	1	No	No	1	0.1	Yes
46	Emory University Hospital, Atlanta	66.6	5	5	5	3,066	2.4	Yes	5	9	No	1	Yes	Yes	1	2.2	Yes
47	University of Chicago Medical Center	66.5	5	5	4	2,113	2.4	Yes	5	9	Yes	1	Yes	No	1	1.3	Yes
48	Keck Medical Center of USC, Los Angeles	66.3	4	5	4	910	2.6	Yes	5	9	No	1	Yes	Yes	1	1.8	Yes
49	Hoag Memorial Hospital Presbyterian, Newport Beach, Calif.	66.0	5	5	5	3,240	1.9	Yes	5	9	No	1	Yes	No	1	0.2	Yes
49	Penn State Health Milton S. Hershey Medical Center, Hershey, Pa.	66.0	5	5	4	3,101	2.1	Yes	5	9	Yes	1	Yes	No	1	0.6	Yes

Rank	Best Hospitals 2023-24: Obstetrics & Gynecology Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Recognized as Nurse Magnet hospital	Public transparency	Expert opinion	Current AHA responder
1	Brigham and Women's Hospital, Boston	100.0	5	5	4	1,302	2.3	Yes	5	9	1	1	7.1	Yes
2	Johns Hopkins Hospital, Baltimore	90.3	5	5	5	515	2.7	Yes	5	9	1	1	6.5	Yes
3	Mayo Clinic, Rochester, Minn.	89.2	5	3	5	1,597	3.1	Yes	5	9	1	1	8.6	Yes
4	Yale New Haven Hospital, New Haven, Conn.	85.0	5	4	3	1,240	2.1	Yes	5	9	1	1	2.6	Yes
5	Stanford Health Care-Stanford Hospital, Stanford, Calif.	84.3	5	3	5	871	3.7	Yes	5	9	1	1	2.1	Yes
6	Cleveland Clinic	83.0	5	3	4	1,045	2.3	Yes	5	9	1	1	8.8	Yes
7	Cedars-Sinai Medical Center, Los Angeles	78.4	5	5	4	670	2.9	Yes	5	9	1	1	1.6	Yes
8	UCLA Medical Center, Los Angeles	77.0	4	5	5	647	3.1	Yes	5	9	1	1	1.9	Yes
9	Tampa General Hospital	73.7	4	5	3	676	2.4	Yes	5	9	1	1	1.0	Yes
9	UW Health University Hospital, Madison, Wis.	73.7	5	5	4	647	2.2	Yes	5	9	1	0	0.6	Yes
11	Long Island Jewish Medical Center at Northwell Health, New Hyde Park, N.Y	73.3	4	5	3	1,475	1.9	Yes	5	9	1	1	2.5	Yes
11	Mount Sinai Hospital, New York	73.3	4	4	3	1,146	2.4	Yes	5	9	1	1	1.8	Yes
13	New York-Presbyterian Hospital-Columbia and Cornell	73.0	3	5	4	1,643	3.0	Yes	5	9	1	1	6.3	Yes
13	University of Alabama at Birmingham Hospital	73.0	3	5	4	1,355	2.3	Yes	5	9	1	1	2.3	Yes
15	UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego	72.4	4	3	4	685	2.2	Yes	5	9	1	1	1.9	Yes
16	Lenox Hill Hospital at Northwell Health, New York	71.4	3	4	3	512	3.7	Yes	5	9	1	1	4.4	Yes
17	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	70.9	4	5	4	441	2.0	Yes	5	9	1	1	4.4	Yes
18	Inova Fairfax Hospital, Falls Church, Va.	70.7	3	5	4	1,851	1.8	Yes	5	9	1	1	0.8	Yes
19	MUSC Health-University Medical Center, Charleston, S.C.	70.1	4	5	4	974	1.8	Yes	5	9	1	1	0.9	Yes
20	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	69.6	3	3	4	720	2.8	Yes	5	9	1	1	2.6	Yes
21	Barnes-Jewish Hospital, Saint Louis	68.3	4	3	4	1,220	2.0	Yes	5	9	1	1	3.4	Yes
22	Vanderbilt University Medical Center, Nashville, Tenn.	67.3	3	4	4	525	2.4	Yes	5	9	1	1	2.4	Yes
23	Aurora St. Luke's Medical Center, Milwaukee	67.2	4	3	4	434	2.3	Yes	5	9	1	1	0.1	Yes
24	John Muir Health-Walnut Creek Medical Center, Walnut Creek, Calif.	66.4	4	4	4	552	2.5	Yes	5	8	1	1	0.0	Yes
25	Houston Methodist Hospital	66.2	4	3	4	514	2.1	Yes	5	8	1	1	1.4	Yes
25	NYU Langone Hospitals, New York	66.2	3	4	4	1,271	2.3	Yes	5	9	1	1	3.7	Yes
27	Duke University Hospital, Durham, N.C.	65.8	3	5	5	958	2.2	Yes	5	8	1	1	4.6	Yes
28	Beaumont Hospital-Royal Oak, Mich.	65.2	4	5	3	818	1.7	Yes	5	9	1	1	0.6	Yes
28	University of Chicago Medical Center	65.2	4	3	4	696	2.4	Yes	5	9	1	1	1.0	Yes
30	West Penn Hospital, Pittsburgh	65.1	4	3	4	1,703	0.9	Yes	5	9	1	1	0.2	Yes
31	AdventHealth Orlando	64.1	4	3	4	2,162	1.5	Yes	5	9	1	1	0.2	Yes
32	Nebraska Methodist Hospital, Omaha	64.0	4	3	4	895	1.5	Yes	5	9	1	1	0.0	Yes
33	Advocate Christ Medical Center, Oak Lawn, Ill.	63.9	4	3	3	808	2.5	Yes	5	9	1	1	0.1	Yes
33	Rush University Medical Center, Chicago	63.9	3	5	4	499	1.8	Yes	5	9	1	1	0.7	Yes
35	Scripps La Jolla Hospitals, La Jolla, Calif.	63.7	3	4	4	738	2.7	Yes	5	9	1	1	0.6	Yes
36	Morristown Medical Center, Morristown, N.J.	63.1	4	3	4	1,081	1.9	Yes	5	9	1	1	0.2	Yes
37	Ohio State University Wexner Medical Center, Columbus	62.4	3	1	4	1,107	2.1	Yes	5	9	1	1	3.1	Yes
38	UMass Memorial Medical Center, Worcester	62.2	4	3	3	621	1.6	Yes	5	9	0	1	0.2	Yes
39	UF Health Shands Hospital, Gainesville, Fla.	61.0	3	3	4	707	2.0	Yes	5	9	1	1	1.0	Yes
40	University of Kentucky Albert B. Chandler Hospital, Lexington	60.9	3	5	4	732	1.6	Yes	5	9	1	1	0.2	Yes
41	West Virginia University Hospitals, Morgantown, W.Va.	60.6	3	3	4	432	2.2	Yes	5	9	1	1	0.2	Yes
42	MemorialCare Long Beach Medical Center, Long Beach, Calif.	60.5	3	5	4	405	2.4	Yes	5	9	1	1	0.4	Yes
43	UT Southwestern Medical Center, Dallas	60.3	3	3	5	509	2.4	Yes	5	9	1	1	1.9	Yes
44	UC Davis Medical Center, Sacramento, Calif.	60.2	3	3	4	624	2.8	Yes	5	9	1	1	0.7	Yes
44	UCSF Health-UCSF Medical Center, San Francisco, Calif.	60.2	3	3	4	506	2.4	Yes	5	9	1	1	4.4	Yes
46	Sarasota Memorial Hospital, Fla.	60.1	3	4	4	569	1.6	Yes	5	9	1	1	0.2	Yes
47	Good Samaritan University Hospital, West Islip, N.Y.	59.6	4	3	3	305	1.3	Yes	5	9	1	0	0.1	Yes
47	Keck Medical Center of USC, Los Angeles	59.6	3	3	4	192	2.6	Yes	5	9	1	1	1.4	Yes
49	Prisma Health Greenville Memorial Hospital, Greenville, S.C.	59.5	4	3	3	880	1.2	Yes	5	9	1	0	0.2	Yes
50	Emory University Hospital, Atlanta	59.1	3	5	5	417	2.4	Yes	5	9	1	1	1.2	Yes

Rank	Best Hospitals 2023-24: Orthopedics Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Prevention of outpatient procedural complications	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Trauma center	Recognized as Nurse Magnet hospital	Expert opinion	Current AHA responder
1	Hospital for Special Surgery, New York	100.0	5	5	5	5	6,522	3.8	Yes	2	7	No	1.0	17.6	Yes
2	Cedars-Sinai Medical Center, Los Angeles	85.0	5	5	3	4	4,416	2.9	Yes	2	7	Yes	1.0	3.5	Yes
3	Mayo Clinic, Rochester, Minn.	84.3	5	3	4	5	6,333	3.1	Yes	2	7	Yes	1.0	15.8	Yes
4	NYU Langone Orthopedic Hospital, New York	81.8	5	5	4	4	7,118	2.3	Yes	2	7	Yes	1.0	7.1	Yes
5	New York-Presbyterian Hospital-Columbia and Cornell	80.0	5	5	5	4	6,344	3	Yes	2	7	Yes	1.0	3	Yes
6	Stanford Health Care-Stanford Hospital, Stanford, Calif.	78.5	5	5	3	5	3,443	3.7	Yes	2	7	Yes	1.0	2.3	Yes
7	Santa Monica-UCLA Medical Center and Orthopedic Hospital, Los Angeles	77.5	5	5	4	5	2,085	3.1	Yes	2	7	Yes	1.0	3.4	Yes
8	Midwest Orthopaedics at Rush University Medical Center, Chicago	76.4	5	5	1	4	2,835	1.8	Yes	2	7	Yes	1.0	5.5	Yes
9	Massachusetts General Hospital, Boston	75.8	5	3	3	5	3,566	2.6	Yes	2	7	Yes	1.0	4.9	Yes
10	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	75.2	5	5	3	3	3,581	2.9	Yes	2	7	Yes	1.0	0.5	Yes
11	Mount Sinai Hospital, New York	74.5	5	5	3	3	2,250	2.4	Yes	2	7	Yes	1.0	0.8	Yes
12	New England Baptist Hospital, Boston	73.8	5	1	5	5	2,828	3.8	Yes	2	4	No	1.0	0.8	Yes
12	UCSF Health-UCSF Medical Center, San Francisco, Calif.	73.8	5	5	4	4	3,212	2.4	Yes	2	7	No	1.0	2.6	Yes
14	Queen's Medical Center, Honolulu	70.5	5	5	5	4	2,256	1.5	Yes	1	6	Yes	1.0	0	Yes
15	Cleveland Clinic	70.0	5	5	2	4	4,031	2.3	Yes	2	7	No	1.0	8.7	Yes
16	Houston Methodist Hospital	69.8	5	5	2	4	3,428	2.1	Yes	2	7	No	1.0	0.9	Yes
16	Scripps La Jolla Hospitals, La Jolla, Calif.	69.8	5	5	3	4	4,703	2.7	Yes	2	6	Yes	1.0	0.5	Yes
18	Hoag Orthopedic Institute, Irvine, Calif.	69.4	5	5	4	5	4,544	1.9	Yes	2	7	No	1.0	1	Yes
19	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	68.4	5	5	4	4	2,118	2	Yes	2	7	Yes	1.0	2.5	Yes
20	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	67.6	5	2	3	4	2,773	2.8	Yes	2	7	Yes	1.0	3.2	Yes
21	Johns Hopkins Hospital, Baltimore	67.2	5	5	5	5	1,824	2.7	Yes	2	7	Yes	1.0	2.7	Yes
22	Duke University Hospital, Durham, N.C.	66.8	5	5	3	5	3,170	2.2	Yes	2	7	Yes	1.0	4.9	Yes
23	Providence Mission Hosp.-Mission Viejo and Laguna Beach, Mission Viejo, Calif.	66.6	5	5	2	4	2,299	2.4	Yes	2	7	Yes	1.0	0.4	Yes
24	University of Michigan Health-Ann Arbor	66.5	5	1	3	5	2,075	2.7	Yes	2	7	Yes	1.0	1.3	Yes
25	Brigham and Women's Hospital, Boston	66.4	5	1	3	4	3,163	2.3	Yes	2	7	Yes	1.0	2.9	Yes
26	Morristown Medical Center, Morristown, N.J.	65.9	5	3	4	4	3,842	1.9	Yes	2	7	Yes	1.0	0.7	Yes
27	Lehigh Valley Hospital-Cedar Crest, Allentown, Pa.	65.8	5	5	4	3	4,382	1.2	Yes	2	7	Yes	1.0	0.1	Yes
28	Mount Sinai Morningside and Mount Sinai West Hospitals, New York	65.4	5	1	5	3	2,296	2	Yes	2	7	Yes	0.0	0.2	Yes
29	Mayo Clinic-Jacksonville, Fla.	65.2	5	5	4	5	1,788	2.6	Yes	2	7	No	1.0	1.9	Yes
30	Florida Orthopaedic Institute at Tampa General Hospital	64.7	5	5	2	3	2,672	2.4	Yes	2	7	Yes	1.0	2.3	Yes
31	Mayo Clinic-Phoenix	64.5	5	5	4	5	1,778	2.3	Yes	2	7	No	1.0	2.1	Yes
32	Lenox Hill Hospital at Northwell Health, New York	63.9	5	5	3	3	2,115	3.7	Yes	2	7	No	1.0	1.1	Yes
33	Hackensack Univ. Med. Ctr. at Hackensack Meridian Health, Hackensack, N.J.	63.6	5	3	4	3	2,314	2.4	Yes	2	7	Yes	1.0	0.7	Yes
34	Long Island Jewish Medical Center at Northwell Health, New Hyde Park, N.Y.	63.2	5	3	4	3	2,473	1.9	Yes	2	7	Yes	1.0	0.5	Yes
34	Rothman Orthopaedics at Thomas Jefferson University Hospitals, Philadelphia	63.2	5	5	2	4	5,267	2.1	Yes	1	7	Yes	1.0	6.2	Yes
34	St. Francis Hospital and Heart Center, Roslyn, N.Y.	63.2	5	3	4	5	1,628	1.8	Yes	2	7	No	1.0	0.1	Yes
37	Barnes-Jewish Hospital, Saint Louis	62.4	4	5	4	4	4,092	2	Yes	2	7	Yes	1.0	3.7	Yes
38	Providence Saint John's Health Center, Santa Monica, Calif.	62.1	5	5	5	4	1,535	2.5	Yes	2	6	No	0.0	0.2	Yes
39	MemorialCare Long Beach Medical Center, Long Beach, Calif.	62.0	5	5	4	4	1,995	2.4	Yes	2	7	Yes	1.0	0.2	Yes
40	NorthShore University Health System-Metro Chicago	61.9	5	1	5	4	4,425	1.3	Yes	2	7	Yes	1.0	0.2	Yes
41	Beaumont Hospital-Royal Oak, Mich.	61.8	5	5	3	3	4,242	1.7	Yes	2	7	Yes	1.0	1	Yes
41	Beaumont Hospital-Troy, Mich.	61.8	5	3	3	4	3,665	1.6	Yes	2	7	Yes	1.0	0.2	Yes
43	Christ Hospital, Cincinnati	61.3	5	1	5	5	2,998	1.7	Yes	2	7	No	1.0	0.1	Yes
43	University of Kansas Hospital, Kansas City	61.3	5	5	2	5	2,296	2.1	Yes	2	7	Yes	1.0	0.3	Yes
45	Memorial Hermann-Texas Medical Center, Houston	61.0	4	5	4	4	3,589	2.4	Yes	2	7	Yes	1.0	0.6	Yes
46	Advocate Good Samaritan Hospital, Downers Grove, Ill.	60.9	5	1	4	4	1,612	2	Yes	2	7	Yes	1.0	0	Yes
46	Montefiore Medical Center, Bronx, N.Y.	60.9	5	2	2	3	1,961	2	Yes	2	7	Yes	0.0	0.6	Yes
48	MedStar Union Memorial Hospital, Baltimore	60.5	5	5	4	3	2,115	2.2	Yes	2	7	Yes	0.0	0.4	Yes
49	Advocate Good Shepherd Hospital, Barrington, Ill.	60.1	5	4	4	4	1,102	2	Yes	2	7	Yes	1.0	0	Yes
50	Penn State Health Milton S. Hershey Medical Center, Hershey, Pa.	59.5	5	5	2	4	2,014	2.1	Yes	2	7	Yes	1.0	0.7	Yes
50	UW Health University Hospital, Madison, Wis.	59.5	5	3	4	4	2,594	2.2	Yes	2	7	Yes	1.0	0.8	Yes

Best Hospitals 2023-24: Pulmonology & Lung Surgery

Rank	Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Trauma center	Recognized as Nurse Magnet hospital	Public transparency	Expert opinion	Current AHA responder
1	Mayo Clinic, Rochester, Minn.	100.0	5	5	5	8,133	3.1	Yes	6	8	Yes	1	1.0	15.4	Yes
2	Cedars-Sinai Medical Center, Los Angeles	98.8	5	5	4	9,843	2.9	Yes	6	8	Yes	1	1.0	3	Yes
3	NYU Langone Hospitals, New York	98.7	5	5	4	20,089	2.3	Yes	6	8	Yes	1	1.0	3.4	Yes
4	UCLA Medical Center, Los Angeles	97.9	5	5	5	6,854	3.1	Yes	6	8	Yes	1	1.0	5.5	Yes
5	Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia	96.2	5	5	4	7,010	2.8	Yes	6	8	Yes	1	1.0	7.5	Yes
6	National Jewish Health, Denver-University of Colorado Hospital	92.8	5	5	4	4,319	2.1	Yes	6	8	Yes	1	1.0	21.2	Yes
7	Stanford Health Care-Stanford Hospital, Stanford, Calif.	91.4	5	5	5	4,715	3.7	Yes	6	8	Yes	1	1.0	2.6	Yes
8	UCSF Health-UCSF Medical Center, San Francisco, Calif.	91.1	5	5	4	3,901	2.4	Yes	6	8	No	1	1.0	8.3	Yes
9	UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego	91.0	5	5	4	4,575	2.2	Yes	6	8	Yes	1	1.0	4.9	Yes
10	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	90.7	5	5	3	10,926	2.9	Yes	5	8	Yes	1	0.0	1.2	Yes
11	Johns Hopkins Hospital, Baltimore	89.9	5	5	5	3,327	2.7	Yes	6	8	Yes	1	1.0	10	Yes
12	Mount Sinai Hospital, New York	89.7	5	5	3	8,855	2.4	Yes	6	8	Yes	1	1.0	2.9	Yes
13	Cleveland Clinic	89.3	5	5	4	6,132	2.3	Yes	6	8	No	1	1.0	12.5	Yes
14	New York-Presbyterian Hospital-Columbia and Cornell	89.1	5	5	4	19,556	3.0	Yes	6	8	Yes	1	1.0	5.5	Yes
15	Houston Methodist Hospital	88.6	5	5	4	8,524	2.1	Yes	6	8	No	1	1.0	0.8	Yes
16	UT Southwestern Medical Center, Dallas	87.0	5	5	5	4,973	2.4	Yes	6	8	No	1	1.0	1.9	Yes
17	Massachusetts General Hospital, Boston	86.4	5	5	5	7,958	2.6	Yes	6	8	Yes	1	1.0	6.5	Yes
18	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	86.2	5	5	4	5,494	2.0	Yes	6	8	Yes	1	1.0	2.2	Yes
19	University of Michigan Health-Ann Arbor	85.5	5	5	5	5,361	2.7	Yes	6	8	Yes	1	1.0	5.4	Yes
20	Rush University Medical Center, Chicago	83.6	5	5	4	3,528	1.8	Yes	5	8	Yes	1	1.0	0.8	Yes
21	Mayo Clinic-Phoenix	83.5	5	5	5	4,648	2.3	Yes	5	8	No	1	1.0	2.3	Yes
22	Lenox Hill Hospital at Northwell Health, New York	82.3	5	5	3	5,246	3.7	Yes	5	8	No	1	1.0	1.6	Yes
23	Barnes-Jewish Hospital, Saint Louis	81.4	5	5	4	6,632	2.0	Yes	6	8	Yes	1	1.0	4	Yes
24	Hackensack Univ. Med. Ctr. at Hackensack Meridian Health, Hackensack, N.J.	80.4	5	5	3	7,553	2.4	Yes	5	8	Yes	1	1.0	0.2	Yes
25	Yale New Haven Hospital, New Haven, Conn.	80.2	5	5	3	11,850	2.1	Yes	5	8	Yes	1	1.0	2.6	Yes
26	Beaumont Hospital-Royal Oak, Mich.	80.0	5	5	3	9,498	1.7	Yes	5	8	Yes	1	1.0	0.2	Yes
27	UC Davis Medical Center, Sacramento, Calif.	79.5	5	5	4	3,847	2.8	Yes	5	8	Yes	1	1.0	0.8	Yes
28	Duke University Hospital, Durham, N.C.	77.7	5	5	5	5,579	2.2	Yes	6	8	Yes	1	1.0	6.3	Yes
28	Long Island Jewish Medical Center at Northwell Health, New Hyde Park, N.Y.	77.7	5	5	3	15,329	1.9	Yes	5	8	Yes	1	1.0	1.1	Yes
30	University of Chicago Medical Center	77.6	5	5	4	3,963	2.4	Yes	6	8	Yes	1	1.0	2.9	Yes
30	University of Kansas Hospital, Kansas City	77.6	5	5	5	5,384	2.1	Yes	6	8	Yes	1	1.0	0.4	Yes
32	Vanderbilt University Medical Center, Nashville, Tenn.	77.5	5	5	4	5,338	2.4	Yes	6	8	Yes	1	1.0	6.1	Yes
33	Baylor University Medical Center, Dallas	77.4	5	5	4	7,604	2.0	Yes	6	8	Yes	1	1.0	0.5	Yes
34	Mayo Clinic-Jacksonville, Fla.	77.2	5	5	5	3,535	2.6	Yes	6	8	No	1	1.0	2.2	Yes
35	UPMC Presbyterian Shadyside, Pittsburgh	76.6	5	5	4	7,236	2.4	Yes	6	8	Yes	1	1.0	3.7	Yes
36	Keck Medical Center of USC, Los Angeles	76.4	5	5	4	1,107	2.6	Yes	6	8	No	1	1.0	1.2	Yes
37	Ohio State University Wexner Medical Center, Columbus	76.2	5	5	4	7,901	2.1	Yes	6	8	Yes	1	1.0	2.1	Yes
38	Huntington Hospital at Northwell Health, Huntington, N.Y.	75.9	5	5	4	5,425	2.2	Yes	5	8	No	1	0.0	0.1	Yes
39	Advocate Christ Medical Center, Oak Lawn, Ill.	75.6	5	5	3	7,436	2.5	Yes	6	8	Yes	1	0.0	0.1	Yes
40	Thomas Jefferson Univ. Hosps.-Jane and Leonard Korman Respiratory Institute, Philadelphia	75.1	5	5	4	5,634	2.1	Yes	5	8	Yes	1	1.0	1.1	Yes
41	Brigham and Women's Hospital, Boston	75.0	5	5	4	5,962	2.3	Yes	6	8	Yes	1	0.0	5.6	Yes
41	Loma Linda University Medical Center, Loma Linda, Calif.	75.0	5	5	4	3,380	2.6	Yes	5	8	Yes	1	1.0	0.2	Yes
43	UF Health Shands Hospital, Gainesville, Fla.	74.9	5	5	4	7,813	2.0	Yes	6	8	Yes	1	1.0	1.2	Yes
44	Kaiser Permanente Anaheim and Irvine Medical Centers, Anaheim, Calif.	74.5	5	5	4	6,110	2.5	Yes	5	8	No	1	0.0	0.3	Yes
44	Morristown Medical Center, Morristown, N.J.	74.5	5	5	4	7,891	1.9	Yes	5	8	Yes	1	1.0	0.1	Yes
46	Advocate Lutheran General Hospital, Park Ridge, Ill.	74.4	5	5	3	6,978	1.8	Yes	5	8	Yes	1	0.0	0	Yes
47	John Muir Health-Walnut Creek Medical Center, Walnut Creek, Calif.	73.9	5	5	4	4,532	2.5	Yes	5	8	Yes	1	0.0	0	Yes
48	St. Francis Hospital and Heart Center, Roslyn, N.Y.	73.4	5	5	5	5,379	1.8	Yes	5	8	No	1	0.0	0.2	Yes
49	Northwestern Lake Forest Hospital, Lake Forest, Ill.	73.3	5	5	4	2,332	1.7	Yes	5	8	Yes	1	0.0	0.1	Yes
50	Queen's Medical Center, Honolulu	73.0	5	5	4	6,832	1.5	Yes	5	8	Yes	1	0.0	0	Yes

Best Hospitals 2023-24: Rehabilitation

Rank	Hospital	U.S. News Specialty Score	Prevention of hospital readmission after discharge	Prevention of hospital readmission during rehabilitation	Discharging patients to home	Flu vaccination rate	Number of patients treated for stroke	Number of patients treated for traumatic brain injury	Number of Medicare patients treated for traumatic spinal cord injury	Number of patients treated for non-traumatic brain injury	Number of patients treated for non-traumatic spinal cord injury	Number of patients treated for neurological conditions	Advanced technologies	Patient services	Designated as rehabilitation innovation center	CARF accreditation	Expert opinion	Current AHA responder
1	Shirley Ryan AbilityLab (formerly Rehabilitation Institute of Chicago), Chicago	100.0	93.8	94.9	64.3	91.6	829	234	217	287	244	258	7	16	1	0	25.1	1
2	Spaulding Rehabilitation Hospital, Charlestown, Mass.	95.1	94.1	95.9	59.7	99.6	651	122	101	204	179	118	7	16	1	1	17.5	1
3	Kessler Institute for Rehabilitation, West Orange, N.J.	86.2	93.6	95.1	65.4	93.9	1,661	246	139	571	258	345	7	16	1	1	11.2	1
4	TIRR Memorial Hermann, Houston	86.0	93.4	95.4	61.6	93.8	493	217	211	187	143	78	7	16	1	1	13.6	1
5	Rusk Rehabilitation at NYU Langone Hospitals, New York	79.6	93.9	96.6	66.2	98.7	282	53	13	115	55	106	7	16	1	1	8.2	1
6	MossRehab, Elkins Park, Pa.	79.3	94.1	95.6	67.5	95.6	944	208	89	158	161	113	7	16	1	1	5.4	
7	UPMC Mercy, Pittsburgh	77.7	93.6	95.8	65.3	95.0	380.0	165.0	84.0	173	143	56	7	16	1	0	6.0	1
8	UW Medicine-University of Washington Medical Center, Seattle	77.4	93.8	96.2	65.0	92.5	93	16	16	67	35	16	7	16	1	1	12.1	1
9	Atrium Health Carolinas Rehabilitation, Charlotte, N.C.	75.6	93.3	96.9	68.9	90.2	706	88	91	274	217	116	7	16	0	1	3.4	1
10	Mary Free Bed Rehabilitation Hospital, Grand Rapids, Mich.	74.7	94.1	96.5	68.3	NR	540.0	108.0	82.0	186	134	134	7	16	1	1	1.5	1
11	Mayo Clinic, Rochester, Minn.	72.1	93.2	95.4	69.3	88.3	122	20	12	54	63	12	7	16	1	1	10.5	1
12	Shepherd Center, Atlanta	69.1											7	16	1	1	6.0	1
13	New York-Presbyterian Hospital-Columbia and Cornell	69.0	93.6	96.2	65.4	96.6	220	24	10	141	63	89	6	16	0	1	7.4	1
14	MedStar National Rehabilitation Hospital, Washington, D.C.	68.3	94.0	95.6	58.8	95.4	557	71	67	130	131	67	7	16	1	1	3.2	1
15	UT Southwestern Medical Center, Dallas	67.9	94.4	96.2	69.9	78.3	185	21	15	110	144	92	7	16	1	1	2.4	1
16	Craig Hospital, Englewood, Colo.	67.7											7	16	1	0	5.4	1
17	Brooks Rehabilitation Hospital, Jacksonville, Fla.	67.3	93.8	96.5	61.5	91.3	703	187	130	231	187	111	7	16	0	1	1.4	1
18	Mount Sinai Hospital, New York	66.9	93.8	96.1	61.8	43.2	186	55	64	74	86	55	7	16	1	1	4.6	1
19	University of Alabama at Birmingham Hospital	66.0	93.5	95.9	73.5	NR	180	74	44	105	107	43	7	16	1	0	1.3	1
19	WakeMed Raleigh Campus, Raleigh, N.C.	66.0	94.2	96.7	70.2	96.1	426	100	62	76	92	74	6	15	0	1	0.0	1
21	California Rehabilitation Institute, Los Angeles	65.0	93.0	95.9	68.4	97.1	546	130	35	598	242	418	7	16	0	1	1.0	1
22	Baylor Scott and White Institute for Rehabilitation-Dallas	64.6	92.7	95.7	68.7	96.0	275	75	100	95	114	188	7	16	1	1	1.5	1
23	Magee Rehabilitation Hospital-Jefferson Health, Philadelphia	64.2	93.9	95.2	69.1	84.3	280.0	44.0	129.0	86	140	35	7	16	0	1	3.1	1
24	Memorial Regional Hospital, Hollywood, Fla.	63.7	92.8	96.7	69.8	92.7	448	107	23	203	82	218	7	14	0	1	0.5	1
25	St. David's Medical Center, Austin	63.6	94.5	96.9	73.8	46.4	309	79	30	240	101	260	6	15	0	0	0.0	1
26	UW Medicine/Harborview Medical Center, Seattle	62.5	93.7	95.8	59.9	88.7	137	57	79	31	83	10	7	16	1	1	3.1	1
27	Ohio State University Wexner Medical Center, Columbus	61.6	93.3	95.2	60.7	89.3	166	76	23	90	86	54	7	16	1	1	4.5	1
27	University of Michigan Health-Ann Arbor	61.6	93.7	95.9	64.7	95.4	28	13	32	36	62	37	7	15	1	0	3.6	1
29	Lancaster Rehabilitation Hospital, Lancaster, Pa.	61.5	94.8	97.2	74.4	98.5	257	75	10	110	57	169	5	7	0	1	0.0	1
29	Sheltering Arms Institute, Richmond, Va.	61.5	93.3	95.6	71.1	84.3	504	146	91	167	116	328	4	12	1	0	0.5	1
31	Sarasota Memorial Hospital, Fla.	61.2	94.4	97.1	66.8	75.8	250	95	17	97	38	57	7	15	0	1	0.0	1
32	Burke Rehabilitation Hospital, White Plains, N.Y.	60.8	95.0	94.6	63.5	97.2	865	92	44	139	172	134	6	15	0	1	1.2	1
33	Sunnyview Rehabilitation Hospital, Schenectady, N.Y.	60.6	94.2	95.8	66.9	94.1	531	93	31	83	61	91	7	16	0	1	0.2	1
34	OhioHealth Rehabilitation Hospital, Columbus, Ohio	60.5	93.6	96.6	65.5	62.5	353	120	41	122	83	96	7	16	0	1	0.2	1
35	Northwestern Medicine Marianjoy Rehabilitation Hospital, Wheaton, Ill.	60.1	93.9	94.9	58.0	97.5	700	157	50	310	146	288	7	16	0	1	1.4	1
36	Moses H. Cone Memorial Hospital, Greensboro, N.C.	59.7	94.5	96.4	74.0	95.0	357	45	18	52	47	44	5	15	0	1	0.0	1
37	Barrow Neurological Institute, Phoenix	59.6	93.7	96.7	62.5	97.0	191	57	52	152	125	29	7	16	0	1	0.2	1
38	Cleveland Clinic Rehabilitation Hospital, Avon, Ohio	59.4	93.0	95.3	63.0	70.5	897	146	52	372	293	591	7	16	0	1	1.1	1
38	Rancho Los Amigos National Rehabilitation Center, Downey, Calif.	59.4	93.5	94.8	65.2	58.0	362	116	126	100	101	102	7	16	1	1	1.2	1
40	Legacy Good Samaritan Medical Center, Portland, Ore.	59.1	94.1	96.3	75.6	66.1	324	37	46	66	42	18	6	15	0	1	0.0	1
41	JFK Johnson Rehabilitation Institute at Hackensack Meridian Health-Edison, N.J.	58.8	94.0	95.0	53.3	97.3	640	144	36	144	73	49	7	16	0	1	3.4	1
42	Rehabilitation Institute of St. Louis	58.6	93.0	96.3	65.9	85.7	537	100	77	288	128	186	4	15	0	1	0.3	1
43	Johns Hopkins Hospital, Baltimore	58.5											7	16	0	1	3.2	1
43	Kaiser Permanente Vallejo Medical Center, Vallejo, Calif.	58.5	93.4	95.7	74.1	73.0	599	53	52	75	50	25	6	15	0	1	1.1	1
45	Lynn Rehabilitation Center at UHealth/Jackson Memorial Hospital, Miami	57.9	92.6	95.7	65.0	49.7	414	90	74	158	316	63	7	15	1	1	0.6	1
46	TriHealth Rehabilitation Hospital, Cincinnati	57.5	94.1	96.3	63.8	97.9	311	39	20	88	56	141	7	16	0	1	0.0	1
47	Craig H. Neilsen Rehabilitation Hospital, Salt Lake City	57.4	93.9	95.6	68.0	99.6	136	29	21	48	46	35	7	16	0	1	2.0	1
48	Banner Rehabilitation Hospital Phoenix	56.9	93.5	96.1	71.3	72.2	650	101	34	151	103	166	5	16	0	0	0.1	1
49	Keck Medical Center of USC, Los Angeles	56.8	93.1	96.6	71.7	100.0	30	10	0	49	59	105	7	16	1	0	0.2	1
50	MetroHealth Medical Center, Cleveland	56.7	92.8	95.7	57.6	96.8	225	74	85	65	86	38	7	16	1	1	1.6	1
50	Santa Clara Valley Medical Center, San Jose, Calif.	56.7	93.7	96.2	76.8	77.3	282	82	65	68	79	29	0	0	1	1	3.4	0

Rank	Best Hospitals 2023-24: Urology Hospital	U.S. News Specialty Score	30-day survival	Discharging patients to home	Prevention of outpatient procedural complications	Patient experience	Number of patients	Nurse staffing	Intensivists	Advanced technologies	Patient services	Trauma center	Recognized as Nurse Magnet hospital	Expert opinion	Current AHA responder
1	Memorial Sloan Kettering Cancer Center, New York	100.0	5	5	5	5	896	2.5	Yes	6	8	No	1.0	6.2	Yes
2	Cleveland Clinic	92.5	5	5	4	4	1,174	2.3	Yes	6	9	No	1.0	19.5	Yes
3	NYU Langone Hospitals, New York	91.6	5	5	4	4	1,140	2.3	Yes	6	9	Yes	1.0	5.6	Yes
4	Mayo Clinic, Rochester, Minn.	89.7	5	5	4	5	963	3.1	Yes	6	9	Yes	1.0	16.5	Yes
5	Cedars-Sinai Medical Center, Los Angeles	87.9	5	5	2	4	772	2.9	Yes	6	9	Yes	1.0	1	Yes
6	New York-Presbyterian Hospital-Columbia and Cornell	87.4	5	5	5	4	1,707	3	Yes	6	9	Yes	1.0	6.7	Yes
7	Johns Hopkins Hospital, Baltimore	86.5	5	5	4	5	687	2.7	Yes	6	9	Yes	1.0	11.4	Yes
8	University of Texas MD Anderson Cancer Center, Houston	85.3	5	5	3	5	1,112	2	Yes	6	9	No	1.0	5.1	Yes
9	Hosps. of the University of Pennsylvania-Penn Presbyterian, Philadelphia	84.8	5	5	5	4	940	2.8	Yes	6	9	Yes	1.0	3.1	Yes
10	UCLA Medical Center, Los Angeles	83.2	4	5	4	5	465	3.1	Yes	6	9	Yes	1.0	10.2	Yes
11	Northwestern Medicine-Northwestern Memorial Hospital, Chicago	83.1	5	5	4	4	967	2	Yes	6	9	Yes	1.0	3.7	Yes
12	UCSF Health-UCSF Medical Center, San Francisco, Calif.	82.2	5	5	4	4	585	2.4	Yes	6	9	No	1.0	8.9	Yes
13	Fox Chase Cancer Center, Philadelphia	81.9	5	5	5	4	503	2.8	Yes	6	9	No	1.0	0.7	Yes
14	Stanford Health Care-Stanford Hospital, Stanford, Calif.	80.8	5	4	4	5	497	3.7	Yes	6	9	Yes	1.0	2.4	Yes
15	Vanderbilt University Medical Center, Nashville, Tenn.	80.5	4	5	4	4	833	2.4	Yes	6	9	Yes	1.0	7.3	Yes
16	Houston Methodist Hospital	79.5	5	5	3	4	579	2.1	Yes	6	8	No	1.0	1.1	Yes
17	North Shore University Hospital at Northwell Health, Manhasset, N.Y.	79.2	5	5	5	3	529	2.9	Yes	6	9	Yes	1.0	0.6	Yes
18	Mount Sinai Hospital, New York	78.0	5	5	5	3	988	2.4	Yes	6	9	Yes	1.0	3.8	Yes
19	University of Michigan Health-Ann Arbor	77.9	4	5	4	5	715	2.7	Yes	6	9	Yes	1.0	7.7	Yes
20	Brigham and Women's Hospital, Boston	76.6	5	5	4	4	740	2.3	Yes	6	9	Yes	1.0	2.5	Yes
21	Keck Medical Center of USC, Los Angeles	76.3	5	5	4	4	959	2.6	Yes	6	9	No	1.0	5.2	Yes
22	Rush University Medical Center, Chicago	74.9	5	5	2	4	380	1.8	Yes	6	9	Yes	1.0	1.4	Yes
23	Duke University Hospital, Durham, N.C.	74.5	4	5	4	5	718	2.2	Yes	6	8	Yes	1.0	4.6	Yes
24	Ohio State University Wexner Medical Center, Columbus	73.5	5	2	3	4	746	2.1	Yes	6	9	Yes	1.0	2.1	Yes
25	UT Southwestern Medical Center, Dallas	72.8	4	5	3	5	1,048	2.4	Yes	6	9	No	1.0	4.3	Yes
26	Beaumont Hospital-Royal Oak, Mich.	72.6	5	5	3	3	498	1.7	Yes	6	9	Yes	1.0	1.8	Yes
27	Hackensack Univ. Med. Ctr. at Hackensack Meridian Health, Hackensack, N.J.	72.5	5	5	3	3	624	2.4	Yes	6	9	Yes	1.0	2.9	Yes
28	Lancaster General Hospital, Lancaster, Pa.	71.2	5	4	4	4	543	1.6	Yes	6	9	Yes	1.0	0	Yes
29	Baylor St. Luke's Medical Center, Houston	70.1	5	4	3	4	483	1.8	Yes	6	9	No	1.0	1.1	Yes
30	Jefferson Health-Thomas Jefferson University Hospitals, Philadelphia	69.9	4	4	4	4	579	2.1	Yes	6	9	Yes	1.0	1.9	Yes
30	Massachusetts General Hospital, Boston	69.9	3	5	4	5	913	2.6	Yes	6	9	Yes	1.0	3.3	Yes
32	UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego	69.1	4	4	2	4	464	2.2	Yes	6	9	Yes	1.0	2.5	Yes
33	UPMC Presbyterian Shadyside, Pittsburgh	68.9	3	5	3	4	1,078	2.4	Yes	6	9	Yes	1.0	1.9	Yes
34	Barnes-Jewish Hospital, Saint Louis	68.8	4	5	2	4	629	2	Yes	6	9	Yes	1.0	2	Yes
34	Froedtert Hospital and the Medical College of Wisconsin, Milwaukee	68.8	4	5	5	4	373	1.7	Yes	6	9	Yes	1.0	0.5	Yes
36	Emory University Hospital, Atlanta	68.6	4	5	2	5	560	2.4	Yes	6	9	No	1.0	1	Yes
37	Mayo Clinic-Phoenix	68.2	3	5	2	5	507	2.3	Yes	6	8	No	1.0	3.2	Yes
38	Lenox Hill Hospital at Northwell Health, New York	68.1	4	3	5	3	408	3.7	Yes	6	9	No	1.0	0.8	Yes
39	New York-Presbyterian Brooklyn Methodist Hospital, Brooklyn	68.0	5	5	4	3	268	1.2	Yes	6	9	Yes	0.0	0	Yes
40	UNC Hospitals, Chapel Hill, N.C.	67.4	4	3	3	4	545	1.7	Yes	6	9	Yes	1.0	2.1	Yes
41	Yale New Haven Hospital, New Haven, Conn.	67.2	4	5	5	3	901	2.1	Yes	6	9	Yes	1.0	0.9	Yes
42	Mayo Clinic-Jacksonville, Fla.	67.1	3	5	4	5	464	2.6	Yes	6	8	No	1.0	2.4	Yes
43	Main Line Health Lankenau Medical Center, Wynnewood, Pa.	66.9	5	3	4	4	221	1.8	Yes	6	9	Yes	1.0	0	Yes
43	Queen's Medical Center, Honolulu	66.9	4	4	2	4	758	1.5	Yes	6	8	Yes	1.0	0	Yes
45	Beth Israel Deaconess Medical Center, Boston	66.8	5	3	5	4	405	1.4	Yes	6	9	Yes	1.0	0.4	Yes
45	UW Medicine-University of Washington Medical Center, Seattle	66.8	3	3	5	4	680	2.1	Yes	6	9	No	1.0	3.3	Yes
47	Long Island Jewish Medical Center at Northwell Health, New Hyde Park, N.Y.	66.3	4	5	3	3	1,058	1.9	Yes	6	9	Yes	1.0	0.9	Yes
48	St. Francis Hospital and Heart Center, Roslyn, N.Y.	66.2	5	5	5	5	296	1.8	Yes	6	9	No	1.0	0.1	Yes
49	Tampa General Hospital	66.0	3	5	2	3	702	2.4	Yes	6	9	Yes	1.0	0.5	Yes
49	University of Chicago Medical Center	66.0	3	3	5	4	394	2.4	Yes	6	9	Yes	1.0	1.9	Yes

Appendix E

2023-2024 Best Hospitals Rankings, Expert Opinion-Based Specialties

Best Hospitals 2023-2024: Ophthalmology

Rank	Hospital	Expert Opinion (%)
1	Bascom Palmer Eye Institute-University of Miami Hospital and Clinics, Miami	35.6
2	Wills Eye Hospital, Thomas Jefferson University Hospitals, Philadelphia	30.9
3	Wilmer Eye Institute, Johns Hopkins Hospital, Baltimore	22.3
4	Mass Eye and Ear, Massachusetts General Hospital, Boston	18.3
5	Stein and Doheny Eye Institutes, UCLA Medical Center, Los Angeles	15.9
6	University of Iowa Hospitals and Clinics, Iowa City	11.1
7	Duke University Hospital, Durham, N.C.	10.6
8	University of Michigan Health Kellogg Eye Center, Ann Arbor	7.5
9	UCSF Health-UCSF Medical Center, San Francisco, Calif.	5.8
10	John A. Moran Eye Center, University of Utah Hospitals and Clinics, Salt Lake City	5.5

Best Hospitals 2023-2024: Psychiatry

Rank	Hospital	Expert Opinion (%)
1	McLean Hospital, Belmont, Mass.	14.6
2	Massachusetts General Hospital, Boston	13.6
3	New York-Presbyterian Hospital-Columbia and Cornell	11.7
4	Johns Hopkins Hospital, Baltimore	9.6
5	Resnick Neuropsychiatric Hospital at UCLA, Los Angeles	8.6
6	UCSF Health-UCSF Medical Center, San Francisco, Calif.	5.2
7	Menninger Clinic, Houston	5.0

Best Hospitals 2023-2024: Rheumatology

Rank	Hospital	Expert Opinion (%)
1	Johns Hopkins Hospital, Baltimore	30.2
2	Hospital for Special Surgery, New York-Presbyterian University Hospital of Columbia and Cornell	20.5
3	Cleveland Clinic	20.2
4	Mayo Clinic, Rochester, Minn.	16.4
5	Brigham and Women's Hospital, Boston	15.3
6	Massachusetts General Hospital, Boston	12.5
7	UCSF Health-UCSF Medical Center, San Francisco, Calif.	10.8
8	NYU Langone Hospitals, New York	9.8
9	UCLA Medical Center, Los Angeles	7.9
10	University of Alabama at Birmingham Hospital	6.4
11	University of Michigan Health-Ann Arbor	5.1

Appendix F

2023-2024 Best Hospitals Honor Roll

2023-2024 Best Hospitals Honor Roll

Hospital (listed alphabetically)
Barnes-Jewish Hospital, Saint Louis
Brigham and Women's Hospital, Boston
Cedars-Sinai Medical Center, Los Angeles
Cleveland Clinic
Hospitals of the University of Pennsylvania-Penn Presbyterian, Philadelphia
Houston Methodist Hospital
Johns Hopkins Hospital, Baltimore
Massachusetts General Hospital, Boston
Mayo Clinic, Rochester, Minn.
Mount Sinai Hospital, New York
New York-Presbyterian Hospital-Columbia and Cornell
North Shore University Hospital at Northwell Health, Manhasset, N.Y.
Northwestern Medicine-Northwestern Memorial Hospital, Chicago
NYU Langone Hospitals, New York
Rush University Medical Center, Chicago
Stanford Health Care-Stanford Hospital, Stanford, Calif.
UCLA Medical Center, Los Angeles
UC San Diego Health-La Jolla and Hillcrest Hospitals, San Diego
UCSF Health-UCSF Medical Center, San Francisco, Calif.
University of Michigan Health-Ann Arbor
UT Southwestern Medical Center, Dallas
Vanderbilt University Medical Center, Nashville, Tenn.

EXHIBIT H

Methodology

U.S. News & World Report 2023-2024 Best Hospitals: Procedures & Conditions Ratings

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August 1, 2023

To Whom It May Concern:

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Executive Summary

Please note that the rankings and ratings are subject to change and are not considered final until published on usnews.com/best-hospitals on August 1, 2023.

This report describes the methodology underlying U.S. News & World Report's 2023-2024 Best Hospitals: Procedures & Conditions ratings of U.S. hospitals' performance in 21 benchmark procedures and conditions. Hospitals ratings, for each procedure and condition we have sufficient data to produce one for, are displayed on scorecards on usnews.com.

The procedures and conditions ratings significantly extend the mission of Best Hospitals: to provide a decision tool that helps the public identify hospitals that best meet their needs. Since 1990, the Best Hospitals rankings have focused on hospitals that excel in treating especially challenging inpatient diagnoses. However, a comparatively small number of patients need such hospitals compared with those who need relatively routine inpatient care. The procedures and conditions in which U.S. News began to rate hospitals in 2015 are much more typical of those needs and represent an integral part of the standard repertoire for most community hospitals. The ratings provide the public with information, using the best data sources we could locate, for consumers choosing, in consultation with their physicians, a local source of competent care.

U.S. News is committed to transparency and therefore publishes detailed descriptions of the methodologies used to rank and rate hospitals. Questions and constructive suggestions can be submitted to bhmethodology@usnews.com. The 2023-2024 ratings evaluate hospitals in the following procedures and conditions:

Abdominal aortic aneurysm repair (AAA)
Aortic valve surgery (AVR)
Back surgery (spinal fusion)
Chronic obstructive pulmonary disease (COPD)
Colon cancer surgery
Heart failure (CHF)
Diabetes
Heart attack
Heart bypass surgery (CABG)
Hip fracture
Hip replacement
Kidney failure
Knee replacement
Leukemia, lymphoma & myeloma
Lung cancer surgery
Ovarian cancer surgery
Pneumonia

Prostate cancer surgery
Stroke
Transcatheter aortic valve replacement (TAVR)
Uterine cancer surgery

Unless otherwise noted, the metrics discussed on this document refer only to the ratings in cohorts cited above. Ratings in other procedures and conditions may be added over time.

More than 4,300 hospitals are evaluated in at least one of the ratings cohorts, using methods developed by health researchers at U.S. News & World Report. Each hospital that meets the rating criteria is assigned to one of three overall performance bands – high performing, average and below average – so that patients and families can quickly identify hospitals whose performance meets or exceeds the national norm. In the 2023-2024 ratings, 1,955 hospitals received a high performing rating in one or more procedures and conditions.

Sources of data include Medicare administrative claims, Medicare Care Compare, the American Hospital Association annual survey, publicly available data from clinical registries, and external designations.

These ratings reflect care received by patients age 65 and older. Older patients are at greater risk – they tend to have a higher incidence and severity of comorbidities upon admission and illnesses that are more advanced than those of younger patients. While the quality of care of over-65 patients is generally regarded as indicative of a hospital's capabilities, U.S. News' assessments are not necessarily applicable to younger patients.

A key aspect of our journalistic approach is our openness to feedback from diverse stakeholders, including patients, healthcare professionals, and the institutions we evaluate. We receive and welcome a steady stream of suggestions via our team inbox, bhmethodology@usnews.com, and we review and carefully consider feedback. We deeply appreciate the time and thought so many correspondents have invested in formulating these suggestions over the past year and in prior years. Our mission is to serve the best interests of patients and to do so, we, like other reputable journalists, are editorially independent of our employer's business operations. To be clear, we give no consideration to whether a correspondent is affiliated with a hospital or health system that advertises in or maintains other commercial agreements with U.S. News. A hospital's license of a "Best Hospitals" badge or its purchase of advertising or other products from U.S. News does not affect whether or not that institution is ranked, either currently or in the future, and, if ranked, whether it is ranked higher or lower. Journalists who participate in creating rankings or ratings are not involved in the sale of products associated with those rankings or ratings.

Changes Implemented in 2023-2024

- We introduced ratings for one additional cancer cohort: leukemia, lymphoma & myeloma.
- A new transparency measure was added to the lung cancer surgery ratings, based on the Society of Thoracic Surgeons (STS) General Thoracic Surgery Database (GTSD) quality improvement program.
- For the discharge to home outcome measure, discharges to an inpatient rehabilitation facility (IRF) were excluded from both the numerator and denominator. Previously these visits were treated as discharges to a location other than home. This change was made to reflect that a discharge to IRF suggests an intermediate outcome, which is less optimal than a discharge home with full recovery but with better prospects for functional recovery than is implied by a discharge to SNF or long-term acute care.
- Two outpatient outcome measures that the Centers for Medicare and Medicaid Services (CMS) has reported on Care Compare were used in relevant ratings: emergency visits following outpatient chemotherapy (used in colon, lung, ovarian, uterine, and prostate cancer ratings); and unplanned admissions following outpatient colonoscopy (used in colon cancer rating).
- We included outpatient volume in addition to inpatient volume for the uterine cancer surgery rating.
- We refined the "patient experience" measure in the back surgery (spinal fusion), hip fracture, hip replacement, and knee replacement cohorts to account for fundamental differences in the clinical attributions of patients treated at specialty hospitals relative to general acute-care hospitals.
- Using criteria from the Elixhauser Comorbidity Software Refined for ICD-10-CM (version v2022.1), risk adjustment of all outcome measures in all procedures & conditions ratings outcome models employed an expanded set of 38 comorbidities.
- We introduced an additional covariate in the COPD cohort's risk-adjustment outcomes models to account for respiratory failure.
- We revised the exclusion criteria related to Covid-19. A visit is excluded only from outcomes analyses if it: a) occurred in March 2020; b) occurred in 2020 and the patient was diagnosed with Covid-19; or c) occurred between April 1, 2020, and December 31, 2020, and the hospital in which the visit occurred experienced a Covid-19 rate higher than the national mean or 15%, whichever was lower, during the month in which the visit occurred. If the patient was diagnosed with Covid-19 in 2021 and onward, the visit is not excluded but is risk adjusted instead. We do not exclude any visits with Covid-19 diagnosis when computing the volume.
- Because volume and nurse staffing measures tend to have skewed distributions, with a small number of extremely high values, these measures were winsorized on the

higher end of their distributions. That is, observed values exceeding a certain threshold were replaced with the threshold score prior to normalization of the measure.

- We refined our denominator inclusion/exclusion criteria for Heart Bypass Surgery and COPD to match the criteria used by CMS in their Care Compare public reporting program.
- We refined our AVR cohort to exclude cases involving both AVR and TAVR procedures. Our TAVR cohort still includes cases involving both AVR and TAVR procedures, as AVR surgery after TAVR failure is rare but sometimes necessary.

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INTRODUCTION

First published in 2015, Best Hospitals: Procedures & Conditions is a key component of the U.S. News & World Report suite of healthcare consumer decision-support tools. For 2023-24, hospitals are rated in 21 common inpatient procedures and conditions:

Abdominal aortic aneurysm repair (AAA)
Aortic valve surgery (AVR)
Chronic obstructive pulmonary disease (COPD)
Colon cancer surgery
Heart failure (CHF)
Diabetes
Back surgery (Spinal fusion)
Heart attack
Heart bypass surgery (CABG)
Hip fracture
Hip replacement
Kidney failure
Knee replacement
Leukemia, lymphoma & myeloma
Lung cancer surgery
Ovarian cancer surgery
Pneumonia
Prostate cancer surgery
Stroke
Transcatheter aortic valve replacement (TAVR)
Uterine cancer surgery

Although these procedures and conditions are services common to community hospitals, many studies demonstrate wide variability between hospitals in the quality of the care they provide. Access to information about the performance of local hospitals enables patients, in consultation with their physicians, to better select hospitals that are the most likely to offer better, safer care.

By focusing on a large number of patients with relatively straightforward needs, these ratings complement the Best Hospitals specialty rankings published annually by U.S. News since 1990. Those rankings identify facilities with demonstrable ability to handle a much smaller but far more challenging patient population of difficult and high-risk cases.

Quality of care has no ready definition or definitive metric, and there is no consensus on the

best way to measure it. Some of its aspects are readily quantifiable while others are more challenging to measure. Moreover, what matters to one patient, such as reported levels of patient satisfaction, may be of little concern to another patient, who might prioritize rates of survival or complications. In addition to offering an overall rating, we publish ratings for the individual elements that make up the overall rating.

Domains of Quality

Like the Best Hospitals specialty rankings, the procedures & conditions ratings use the Donabedian paradigm, which reflects a relationship between structure, process, and outcomes. Avedis Donabedian described this now widely accepted dynamic in 1966[1], which is applied to hospital care as follows:

- *Structure* refers to hospital resources connected with patient care, such as the number of nurses, availability of certain specialists, and accreditations and certifications by outside organizations.
- *Process* refers to the way in which diagnoses, treatments, and practices to avoid harm to patients are rendered – whether steps known to be effective in preventing infections and medical errors, for example, are built into hospital routine.
- *Outcomes* refers to the results of care, including death, harm to patients, preventable readmissions, unusually long hospitalizations, and other consequences.

Failing to acknowledge the influence of random variation in quality metrics can produce results that misleadingly identify one hospital as superior or inferior to another. The methodology for the procedures and conditions ratings takes into account not only how each hospital performs on different measures but also the level of statistical certainty of those performance metrics. Larger sample sizes produce higher statistical confidence, which can result in a high-volume hospital with modestly above average results being rated more highly than a low-volume hospital with comparatively better observed results. This is because the second hospital's performance is more likely due to chance.

An important goal of the methodology is to give patients a clear bottom line. Despite the complexity of the measurement issues and the usefulness of particular types of information such as death and readmission rates, patients deserve an overall conclusion: How well does a hospital perform in a specific procedure or condition, like heart bypass surgery, compared to other hospitals? These ratings aggregate the measures in each cohort of care into an overall assessment by placing a hospital into one of three composite bands: high performing, average, and below average.

Data Sources

1. **Publicly available indicators**. Measures of performance are obtained from the public

[1] Donabedian, A. 1966. Milbank Memorial Fund Quarterly. Evaluating the Quality of Medical Care. 44(3), Part 2, 166-206. doi: 10.2307/3348969. https://www.jstor.org/stable/3348969?seq=1

websites of Care Compare maintained by the Centers for Medicare & Medicaid Services (CMS), the Society of Thoracic Surgeons (STS), the American Heart Association (notably abbreviated GWTG in this document, to refer to their Get With The Guidelines program), the American College of Cardiology (ACC), and the National Cancer Institute (NCI).

2. **Medicare Beneficiary Summary Files (MBSF).** Administered by CMS, the Medicare beneficiary summary files contain demographic and coverage information pertaining to Medicare beneficiaries. All data are de-identified prior to being provided to U.S. News.

3. **Medicare Inpatient Limited Data Set Standard Analytical Files (LDS SAF).** Administered by CMS, the Inpatient LDS SAF contain inpatient hospitalization claims filed on behalf of patients enrolled in traditional Medicare. The LDS SAF provides a thorough administrative record for each patient across all inpatient encounters related to an episode of care. All data are de-identified prior to being provided to U.S. News.

4. **Medicare Outpatient Limited Data Set Standard Analytical Files.** The Outpatient LDS SAF contain final action claims filed by institutional providers for outpatient services covered by the Medicare Part B benefit. As with the other LDS SAF, all data are de-identified prior to being provided to U.S. News. Data from these files are used in order to attribute the volume of procedures performed in the outpatient setting by each hospital in the knee replacement, hip replacement, prostate cancer surgery, and uterine cancer surgery cohorts as well as to identify cases in which patients in the stroke cohort were initially seen in an emergency department before being transferred and admitted to another hospital, and whether or not they received reperfusion therapy. The analysis uses both the Base Files, which contain the base claim record and header information, as well as the Revenue Center Files, which contain line level HCPCS codes for each procedure.

5. **Medicare Skilled Nursing Facility (SNF) Limited Data Set Standard Analytical Files.** The SNF LDS SAF contain final action claims filed by institutional providers for skilled nursing facility services covered by the Medicare Part A benefit. As with the other LDS SAF, all data are de-identified prior to being provided to U.S. News. Data from these files are used to augment information on discharge, admission, and time at home.

6. **American Hospital Association (AHA) Annual Survey.** Through its Health Forum arm, the AHA surveys all U.S. hospitals annually (including AHA nonmembers) to obtain operational and clinically relevant information, such as types and levels of staffing. The collected data is the most complete of its kind available on U.S. hospitals.

7. **Hospital Consumer Assessment of Healthcare Providers and Systems Survey**

(HCAHPS). The federal government releases quarterly results of ongoing surveys of recently discharged inpatients conducted by more than 4,000 hospitals. The results comprise a rolling 12-month assessment of inpatients' opinions about their stay in various respects such as staff communication, treatment of pain and overall opinion of the hospital. The procedures & conditions ratings incorporate overall patient opinions into the methodology. Other HCAHPS survey results are displayed but not integrated into the ratings. Because the government aggregates HCAHPS data across each hospital, patients' opinions about their care in specific departments cannot be determined.

8. **Orthopedic Board Certification Data.** Information on physicians' board certification status in orthopedic surgery is obtained from the American Board of Orthopaedic Surgery (ABOS), the National Board of Physicians and Surgeons (NBPS), and the American Osteopathic Association (AOA), via Doximity. (Disclosure: U.S. News & World Report holds an equity interest in Doximity.)

9. **Total Volume Data from the American Hospital Directory (AHD).** Data from AHD contain hospital-level total volume and Medicare Advantage (MA) volume by year for approximately 4,400 hospitals. AHD calculates this information using the CMS MEDPAR data set. Because the Inpatient SAF files contain information for only traditional fee-for-service (FFS) Medicare beneficiaries, this data set is used to estimate the proportion of a hospital's inpatient services provided to MA patients in order to adjust the volume measure and thus account for all visits, not just FFS visits.

Selection of Procedures and Conditions

Procedures and conditions are selected based on the frequency of admission in the Medicare population, the ability to make hospital-to-hospital comparisons, and the presence of a sufficient degree of risk or complexity such that the quality of a hospital's performance could be important.

Table 1: *Procedures and Conditions and Number of Patient Visits by Cohort, 2017-2021**

	Estimated Medicare Volume	
	Rated Hospitals	*All Hospitals*
Abdominal aortic aneurysm repair	103,554	105,121
Aortic valve surgery	71,398	72,552
Back surgery (Spinal fusion)	446,145	447,543
Chronic obstructive pulmonary disease (COPD)	1,774,651	1,775,901
Colon cancer surgery	187,303	192,240
Diabetes	332,423	339,620
Heart attack	1,194,989	1,200,745
Heart bypass surgery	370,353	370,414
Heart failure	3,248,434	3,249,738
Hip fracture	1,230,577	1,231,904
Hip replacement†	1,029,642	1,033,039
Kidney failure	1,383,492	1,387,960
Knee replacement†	1,993,486	1,995,973
Leukemia, lymphoma & myeloma	251,539	256,441
Lung cancer surgery	111,961	113,745
Ovarian cancer surgery	24,622	26,103
Pneumonia	3,581,827	3,582,277
Prostate cancer surgery†	153,555	159,462
Stroke	1,459,271	1,463,988
Transcatheter aortic valve replacement (TAVR)	320,702	320,946
Uterine cancer surgery†	78,539	85,982

* *Estimates include fee-for-service and estimated Medicare Advantage visits.*
† *The volume measure also includes procedures performed on an outpatient basis.*

Table 1 above lists the procedures and conditions evaluated for publication, along with Medicare inpatient visit volume at both rated hospitals (those with 15 or more adjusted patient visits over the evaluation window) and at all hospitals, rated and unrated. This reflects the number of patient visits during the five-year period from January 2017 through December 2021 (referred to as 2017-2021 throughout this document). As the table shows, most Medicare patient visits in these cohorts received care at hospitals that received a rating.

The cohorts created in this project are not identical to those created by CMS or other organizations in their performance indicators. In defining inclusion and exclusion criteria, three aims are paramount for maximizing statistical and clinical accuracy:

1. **Maximal homogeneity:** patients are as alike as possible other than with regard to factors that could be adequately managed through risk-adjustment.
2. **Maximal sample size:** selection of procedure and condition cohorts is limited to those with a sufficiently large volume of care for statistical robustness and meaningfulness.
3. **Minimal coding variation:** coding definitions are relatively immune to large variations due to differences in coding practices. In considering this issue, it is particularly

important to try to avoid systematic biases that might benefit particular organizations and encourage gaming, as opposed to random coding variations that would simply add noise and reduce precision.

These three goals are not in harmony. While (1) argues for narrowly defined patient cohorts, (2) and (3) argue for broader inclusion criteria. This dynamic factors into determining which procedures and conditions we rate.

When we rate procedures or conditions for which CMS has also developed quality measures, we largely derive cohort definitions and specifications using CMS's algorithms. However, based on our analyses and findings from scientific literature, our cohort and outcome inclusion/exclusion criteria may differ from CMS. Our aim is to mitigate any potential effect of variations in hospitals' coding practices on the homogeneity of the cohort or the results of the outcome analyses.Using procedure codes to exclude patients from a cohort or to risk-adjust may be inappropriate if the choice of code and/or procedure is within a doctor's or hospital's discretion. In such cases, exclusion or risk-adjustment by procedure code could encourage upcoding, or perversely reward a hospital for performing a higher-risk procedure when a lower-risk alternative may be indicated, such as selection of open surgery over a minimally invasive procedure.

To the extent that a hospital's use of different interventions and associated procedure codes is a reliable indicator of a patient's risk, the desire for homogeneity suggests using procedure codes for risk-adjustment or to define exclusion criteria. However, to the extent that the use of different procedures represents a hospital's decisions in treating an otherwise homogeneous group of patients, procedure codes should not be used in this way. This last issue is of particular concern, since using procedure codes in this way could encourage manipulation of data. With these considerations in mind, we define our cohorts as follows:

Procedures

Abdominal aortic aneurysm repair. This cohort includes predominantly endovascular (closed) repair of abdominal aortic aneurysm, with the exception of risk-adjusted survival, where we include open repair and adjust for approach. This cohort excludes repairs in other locations, as well as ruptured aneurysms and those with a claim admission type code of "1", indicating an emergent procedure. Patients undergoing emergent surgery typically are unable to choose which hospital they visit.

Aortic valve surgery. This cohort includes isolated open surgical aortic valve replacement and excludes concurrent coronary artery bypass. Transcatheter aortic valve therapies, which have become increasingly common since the time period covered by this analysis, are analyzed separately in the TAVR cohort, described in further detail below.

Colon cancer surgery. This cohort includes colon resection for colon cancer.

Back surgery (spinal fusion). This cohort includes thoracolumbar, lumbar, and lumbosacral spinal fusions, performed on patients with degenerative spinal conditions, and excludes spinal fractures or dislocations, spinal cord injuries, congenital or other anomalies, inflammatory spondylopathy, osteoporosis, and traumas, which may indicate non-elective spine surgery.

Heart bypass surgery. This cohort includes isolated open coronary artery bypass graft (CABG) and excludes concurrent valve replacement, repair, and other significant cardiac procedures. The denominator definition is aligned with that of CMS.

Hip fracture. This cohort includes surgical repairs for pathologic or traumatic fractures of the hip, femoral head, or upper femur, and excludes fractures which received only medical care, minor procedures, or percutaneous interventions.

Hip replacement. This cohort includes primary arthroplasty of the hip for osteoarthritis and excludes partial joint replacement, revision, concurrent fracture, and concurrent hip and knee replacement. The volume measure includes procedures performed on an outpatient basis from January 2020 through the end of the analytic period.

Knee replacement. This cohort includes primary arthroplasty of the knee for osteoarthritis and excludes partial joint replacement, revision, and concurrent hip and knee replacement. The volume measure includes procedures performed on an outpatient basis from January 2018 through the end of the analytic period.

Lung cancer surgery. This cohort includes lobectomy, pneumonectomy, and sublobar resection, for lung cancer.

Ovarian cancer surgery. This cohort includes primary oophorectomy, hysterectomy, salpingectomy, and trachelectomy, for ovarian cancer.

Prostate cancer surgery. This cohort includes prostatectomy, as well as resection or excision of related structures often removed during the process of prostatectomy, including bilateral seminal vesicles, vas deferens, and pelvic lymph nodes, for prostate cancer. The volume measure includes procedures performed on an outpatient basis during the analytic period.

TAVR. This cohort includes all approaches (e.g. transfemoral and transapical) of isolated transcatheter aortic valve replacement. This procedure has emerged in recent years as a feasible, safe, and less invasive alternative to surgical aortic valve replacement (AVR). In 2011, TAVR was approved as an alternative to AVR for high risk patients. Since then approval has expanded, and the volume of TAVR in the Medicare SAF database now eclipses that of surgical AVR.

Uterine cancer surgery. This cohort includes primary hysterectomy, oophorectomy, salpingectomy, or trachelectomy, for uterine cancer. New for the 2023-2024 ratings, the volume

measure includes procedures performed on an outpatient basis during the analytic period.

Conditions

CHF. This cohort includes principal nonhypertensive congestive heart failure, congestive heart failure, and certain other heart failure subgroups.

COPD. This cohort includes principal chronic obstructive pulmonary disease and bronchiectasis. The denominator definition is aligned with that of CMS.

Diabetes. This cohort includes principal Type I and Type II diabetes mellitus, as well as certain "other specified" diabetes mellitus.

Heart attack. This cohort includes principal acute myocardial infarction and excludes cardiac arrest and cardiogenic shock, as defined by CMS.

Kidney failure. This cohort includes principal acute kidney failure and excludes end stage renal disease indicated by diagnosis or Medicare status code as well as concurrent kidney transplant.

Leukemia, lymphoma & myeloma. This cohort includes principal leukemia, lymphoma and myeloma, as well as secondary leukemia with a principal diagnosis indicating treatment via chemotherapy.

Pneumonia. This cohort includes both isolated principal pneumonia and principal sepsis with secondary pneumonia and without a secondary severe sepsis, as defined by CMS.

Stroke. The stroke cohort includes principal ischemic stroke, as defined by CMS.

Visits that meet criteria for both a procedure and a condition cohort during the same inpatient visit are usually limited to inclusion in the procedure cohort. However, if a visit is associated with either the TAVR or AVR cohort and the CHF cohort, or a visit is associated with the CABG cohort and either the heart attack or CHF cohort, the visit is included in both the procedure cohort and the condition cohort.

Inclusion of Providers and Case

No application, data submission, or other action is required for consideration of Best Hospitals for Procedures & Conditions ratings. All facilities listed in the AHA Annual Survey Database are automatically considered, whether or not they have responded to the AHA's survey.

All hospitals represented in the 2021 AHA survey were initially considered for inclusion in the ratings analysis, unless categorized on the survey by a control (CNTRL) code (40-48) indicating federal government ownership.

Hospitals were also excluded if they lacked a valid six-digit Medicare provider number (MPN) to attribute to their AHA entity. In some cases, we attributed visits from multiple MPNs to a single AHA entity. This occurred when, in the judgment of U.S. News, the AHA entity encompassed

the operations of two or more clinically integrated facilities or campuses that maintained separate MPNs during any portion of the analytic period.

In the condition cohorts only, we excluded hospitals with primary service (SERV) codes indicating service types other than general acute care, tuberculosis and other respiratory diseases, and heart, from rating eligibility, except in relevant specialties. Cancer hospitals were included only for the colon cancer surgery, lung cancer surgery, ovarian cancer surgery, prostate cancer surgery, uterine cancer surgery, and leukemia, lymphoma & myeloma cohorts; respiratory hospitals were included only for lung cancer surgery, COPD, and pneumonia cohorts; and heart hospitals were excluded for diabetes, pneumonia, and kidney failure cohorts.

Table 2: *Number of Hospitals, by Cohort*

	Rated	**All**
Abdominal aortic aneurysm repair	1,207	1,568
Aortic valve surgery	793	1,044
Back surgery (Spinal fusion)	1,725	2,068
Chronic obstructive pulmonary disease (COPD)	4,063	4,280
Colon cancer surgery	2,266	3,254
Diabetes	2,857	4,120
Heart attack	2,641	3,859
Heart bypass surgery	1,043	1,144
Heart failure	4,072	4,279
Hip fracture	2,964	3,300
Hip replacement	2,636	3,178
Kidney failure	3,509	4,204
Knee replacement	2,922	3,325
Leukemia, lymphoma & myeloma	1,826	3,136
Lung cancer surgery	1,037	1,547
Ovarian cancer surgery	461	953
Pneumonia	4,201	4,282
Prostate cancer surgery	1,121	2,075
Stroke	3,225	4,082
Transcatheter aortic valve replacement (TAVR)	749	793
Uterine cancer surgery	517	1,214

A small number of additional hospitals are excluded from ratings in individual cohorts where their volume is not large enough to allow estimation for at least one outcome used in that cohort. This occurred, for instance, with hospitals that began offering knee replacement near the end of our analytic period, but performed no surgeries during the surveillance period for postoperative

infection in that cohort.

Cohort ratings are displayed on usnews.com for all other hospitals with adjusted cohort volume of at least fifteen visits (fee-for-service cases plus estimated managed care cases). For hospitals with Medicare Advantage-adjusted cohort volumes of fewer than fifteen visits, we display information on selected metrics, but not overall composite ratings or claims-based outcome measures. The number of hospitals rated in each of the cohorts is shown in **Table 2.** Note that the numbers in **Table 2** are inclusive of hospitals that have closed, or closed their evaluated service line(s), in order to include the fullest volume in our analysis.

Inpatient visits are aggregated from multiple claims (if needed), then excluded from cohort eligibility if they are missing key information for modeling purposes, contain data that were logically inconsistent, or otherwise indicate data entry errors, i.e.:

- The patient did not appear in the MBSF
- The patient sex was not identified
- The length of stay was greater than 365 days
- The patient date of death was prior to the admission date or relevant procedure date
- The patient had multiple dates of death
- The discharge was against medical advice

Visits from patients less than 65 years old are also excluded, because they represent a distinct population with a different medical profile than other Medicare patients.

Outcomes

Outcomes are primarily derived from the 2017-2021 LDS SAF inpatient data set, which enables us to capture and attribute them to the index hospital, even if a patient experienced that outcome outside of that hospital or at a different facility. The surveillance periods from which index visits are drawn vary, depending on the pre- and post-admission or surgery surveillance requirements specific to each measure, in order to capture the most recent data available that meet those requirements.

Certain visits were excluded from outcome analyses to control for the disruptive and variable effects of the Covid-19 pandemic. A visit was excluded if it: a) occurred in March 2020; b) occurred in 2020 and the patient was diagnosed with Covid-19; or c) occurred between April 1, 2020 and December 31, 2020, and the hospital in which the visit occurred experienced a Covid-19 rate higher than the national mean or 15%, whichever was lower, during the month in which the visit occurred. If the patient was diagnosed with Covid-19 in 2021 and onward, the visit is not excluded but is risk-adjusted instead.All claims-based outcomes are risk-adjusted using a multi-level (hierarchical) logistic regression model that controls for potential confounders, with a random intercept for

hospital identity. Details on the results and performance of risk-adjustment models for each cohort are listed under "Evaluation of Risk-Adjustment Models". In all instances, hospital-specific random intercepts are treated as continuous measures in composite modeling in order to make maximum use of the information contained in the variable, and to minimize the risk of measurement error due to categorization. Categorical groupings and descriptions of hospital-specific random intercepts are displayed on scorecards. The details are listed under "Categorical Display".

The following claims-based, risk-adjusted outcomes are used in the final composite models to evaluate each hospital's performance relative to others in the cohort. The relative contributions of each outcome to the overall cohort ratings are depicted under "Indicators and Correlations With Scores." Surveillance windows for index cases are provided in parentheses after each description.

1. **Mortality within 30 days (labeled "Survival" on scorecards)**. Reflects death within 30 days of surgery for procedure cohorts, or 30 days of admission for condition cohorts. (11/30/2016 - 12/1/2021)
2. **Unplanned readmission within 30 days ("Readmission prevention").** Unless otherwise noted, reflects unplanned inpatient readmission within 30 days of discharge, similar to the CMS hospital-wide 30-day unplanned readmission measure definition[2]. For some cohorts, this measure may reflect additional cohort-specific criteria[3,4,5]. (11/30/2016 - 12/1/2021)
3. **Surgical site infection ("Infection prevention"), hip replacement, knee replacement, AAA, CABG, and AVR cohorts**. Reflects development of a surgical site

[2] Horwitz, L. I., Partovian, C., Lin, Z., Grady, J. N., Herrin, J., Conover, M., Drye, E. E. (2014). Development and use of an administrative claims measure for profiling hospital-wide performance on 30-day unplanned readmission. *Annals of Internal Medicine*, *161*(0), S66–S75. http://doi.org/10.7326/M13-3000

[3] Center for Medicare & Medicaid Services. (n.d.). *Coronary Artery Bypass Graft (CABG) Surgery 30-day readmission rate*. Measure Details. https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=1426.

[4] Center for Medicare & Medicaid Services. (n.d.). *30-Day Unplanned Readmissions for Cancer Patients*. Measure Details. https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=6030.

[5] Center for Medicare & Medicaid Services. (n.d.). *Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) 30-day readmission rate*. Measure Details. https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=899.

infection following the index procedure. Published literature[6,7,8,9,10] indicates that a careful approach to constructing claims-based infection measures can accurately identify hospitals with unusually low or high infection rates.
(12/31/2015 - 12/31/2020 for hip replacement and knee replacement, 10/31/2016 - 11/1/2021 for AAA, CABG, and AVR)

4. **Revision within 1 year ("Prevention of revision surgery"), hip replacement and knee replacement cohorts**. Reflects subsequent procedure to address problems with a joint replacement within 1 year of the original surgery.
(12/31/2015 - 12/31/2020)
5. **Prolonged hospitalizations ("Prevention of prolonged hospitalization"), leukemia, lymphoma & myeloma and procedure cohorts**. Reflects length of stay duration in the highest quartile.
(11/30/2016 - 12/1/2021)
6. **Discharge to a location other than the patient's home ("Discharging patients directly home").** Reflects discharge to a location other than home, such as a long-term acute care facility or a different hospital. More details are provided in Appendix A.
(12/30/2016 - 12/31/2021)
7. **Stroke on procedure date ("Prevention of stroke"), CABG, AVR, and TAVR cohorts.** Reflects stroke on the index procedure date.
(12/30/2016 - 12/31/2021)
8. **Time spent at home within 30 days of discharge ("Giving patients time at home").** Reflects whether the amount of time spent at home within the 30 days after a hospital visit was above or below average.
(12/30/2016 - 12/31/2021)

Other claims-based, risk-adjusted outcome measures have been investigated but are not in this year's composite models, including time to joint revision within five years, complications of total

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[6] Calderwood, M. S., A. Ma, Y. M. Khan, M. A. Olsen, D. W. Bratzler, D. S. Yokoe, D. C. Hooper, *et al.* "Use of Medicare Diagnosis and Procedure Codes to Improve Detection of Surgical Site Infections Following Hip Arthroplasty, Knee Arthroplasty, and Vascular Surgery." *Infect Control Hosp Epidemiol* 33, no. 1 (Jan 2012): 40-9.

[7] Letourneau, A. R., M. S. Calderwood, S. S. Huang, D. W. Bratzler, A. Ma, and D. S. Yokoe. "Harnessing Claims to Improve Detection of Surgical Site Infections Following Hysterectomy and Colorectal Surgery." *Infect Control Hosp Epidemiol* 34, no. 12 (Dec 2013): 1321-3.

[8] Calderwood, M. S., K. Kleinman, D. W. Bratzler, A. Ma, R. E. Kaganov, C. B. Bruce, E. C. Balaconis, *et al.* "Medicare Claims Can Be Used to Identify Us Hospitals with Higher Rates of Surgical Site Infection Following Vascular Surgery." *Med Care* 52, no. 10 (Oct 2014): 918-25.

[9] Calderwood, M. S., K. Kleinman, D. W. Bratzler, A. Ma, C. B. Bruce, R. E. Kaganov, C. Canning, *et al.* "Use of Medicare Claims to Identify Us Hospitals with a High Rate of Surgical Site Infection after Hip Arthroplasty." *Infect Control Hosp Epidemiol* 34, no. 1 (Jan 2013): 31-9.

[10] Calderwood, M. S., Kleinman, K., Murphy, M. V., Platt, R., Huang, S. S. "Improving Public Reporting and Data Validation for Complex Surgical Site Infections After Coronary Artery Bypass Graft Surgery and Hip Arthroplasty." Open Forum Infectious Diseases 1, no. 3 (Dec 2014).

joint replacement (NQF #1550[11]), and a readmission measure for cancer cohorts (closely following specifications developed by the Alliance of Dedicated Cancer Centers).

Process Measures

We evaluate a variety of process measures, obtained primarily from the CMS Care Compare website as well as the inpatient claims data sets. Most are excluded prior to modeling, due to missing data or other data validity concerns, while others did not demonstrate good empirical fit. The following measures are included in the composite model for one or more cohorts:

- **Worker flu immunization.** Percentage of healthcare personnel at the hospital who received a timely vaccination during flu season. Derived from the CMS Care Compare Database.
- **Noninvasive ventilation.** Percentage of patients who need assistance with breathing treated with noninvasive breathing aid, which means that the hospital uses a mask, instead of inserting a breathing tube or performing surgery, to provide respiratory support. A dichotomized measure with the 20% threshold was used for the heart failure cohort since the transformed measure was better correlated with CHF's other quality indicators for this year's analysis periods (i.e. 2017-2021 data). For COPD, the continuous measure was better associated with COPD's other quality measures.
- **Patient experience.** Overall hospital linear mean score of recently discharged patient experience from the HCAHPS survey from the 4/1/2021-3/31/2022 data[12]. We use this score over the star rating because it is a continuous measure that provides more information.

  In our back surgery (spinal fusion), hip fracture, hip replacement, and knee replacement cohorts we introduced an adjustment to account for the fact that HCAHPS scores tend to be higher at specialty hospitals versus general acute-care hospitals. Based on our own research and feedback from the medical community, we believe this is due to different characteristics in the patient population and not wholly the result of different outcomes. The group mean adjustment we are introducing brings the mean HCAHPS scores at specialty hospitals closer to the mean scores at general hospitals to ensure that scores are comparable across hospital service categories. Our adjustment formula is as follows:

$$y_q = \max(0, x_q - \left(\frac{1 - x_q}{1 - \overline{x}_q}\right) \times (\overline{x}_q - \overline{x}_p))$$

  where y_q and x_q refer to a specialty hospital's adjusted and unadjusted HCAHPS scores,

[11] Centers for Medicare & Medicaid Services. (2019, September). *Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550).* https://innovation.cms.gov/files/fact-sheet/bpciadvanced-fs-nqf1550.pdf.

[12] The current version of the survey is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html.

respectively; $\bar{x}_q$ is the mean score at all specialty hospitals; and $\bar{x}_p$ is the mean score at all general hospitals. As a result of this adjustment, a specialty hospital with a perfect unadjusted score will receive a perfect adjusted score, whereas a specialty hospital with an unadjusted score equal to the mean score among specialty hospitals will receive an adjusted score equal to the mean score among general hospitals.

- **Board certification.** Percentage of hip replacement, knee replacement, and hip fracture repair visits, respectively, performed by board-certified orthopedic surgeons. The measure accounts for both MDs and DOs. Board-certified orthopedic surgeons are identified in data provided by ABOS and AOA to Doximity prior to January 26, 2023and (b) self-reported by NBPS-certified orthopedic surgeons to Doximity prior to January 26, 2023. Surgeons are linked to the hospitals where they operate using National Provider Identifier information on Medicare claims rather than hospital affiliations reflected in doctors' Doximity profiles.
- **Emergency room visits after chemotherapy.** How well the hospital prevents patients who received outpatient chemotherapy from needing to go to the emergency room. The surveillance period is from 01/01/2021 to 12/31/2021. Derived from the CMS Care Compare database.
- **Unplanned visits after colonoscopy.** How well the hospital prevents patients who had a colonoscopy from needing to be admitted unexpectedly. The surveillance period is from 01/01/2019 to 12/31/2021. Derived from the CMS Care Compare database.
- **Compliance with the septic shock bundle.** Level of compliance with septic shock 6-hour bundle, a collection of treatments recommended to be completed within 6 hours of septic shock by the Surviving Sepsis Campaign. The surveillance period is from 04/01/2021 to 03/31/2022. Derived from the CMS Care Compare database.
- **Public transparency.** Public transparency measures were incorporated into seven ratings, based on hospitals' public reporting status in relevant clinical registries. This is done in part to encourage all hospitals, regardless of performance, to release their data and by doing so expand the data universe. As a result, it has the advantages of allowing researchers to evaluate the results of hospital ratings, facilitating informed decision making by patients, and demonstrating a public commitment of pursuing quality improvement. **Table 3** shows which registries correspond to each cohort.
    - **GWTG recognized hospital.** Hospitals receive credit in this measure by voluntarily reporting quality metrics to the public through websites maintained by the American Heart Association under its GWTG quality improvement programs. In order to receive a credit, hospitals must have opted into the public reporting program and been appearing on their public reporting site by 8/31/2022.
    - **ACC recognized hospital.** Hospitals receive credit for participating in the ACC National Cardiovascular Disease Registry data-reporting initiatives if they also agreed to allow their ACC-calculated results to be publicly reported on the ACC's website. To receive credit for ACC public reporting, hospitals must have voluntarily agreed to

allow data from at least one of these registries to be posted on the ACC registry website, www.CardioSmart.org.

- **STS recognized hospital.** Hospitals receive credit in heart bypass surgery, aortic valve surgery, and lung cancer surgery cohorts if they permit STS to publicly report their performance data. Published research by STS-affiliated researchers[13] and independent analysis by U.S. News found that hospitals that do not publicly report via STS performed worse than STS reporters on quality measures such as risk-adjusted mortality, morbidity and readmissions following heart surgery. While not establishing the direction of causality, these observed correlations between STS-mediated transparency and better outcomes support the use of transparency as an indicator of higher quality of care.[14]
- **STS/ACC TVT registry recognized hospital.** Hospitals receive credit for participating in the STS/ACC TVT Registry, created and maintained through a collaboration between STS and ACC, if they also allowed their results to be publicly reported on the registry website.

Table 3: *Public Transparency*

Cohort	Public Reporting Program	Source
AVR	STS ACSD	Society of Thoracic Surgeons
CABG	STS ACSD	Society of Thoracic Surgeons
TAVR	STS/ACC TVT	Society of Thoracic Surgeons
Lung cancer surgery	STS GTSD	Society of Thoracic Surgeons
Heart attack	ACC FYHH*	American College of Cardiology
(either registry)	GWTG-Heart†	American Heart Association
Heart failure	GWTG-Heart†	American Heart Association
Stroke	GWTG-Stroke	American Heart Association

* *For ACC FYHH credit, hospital has to publicly report data in at least one of the following registries: EP Device Implant (formerly ICD), Chest Pain - MI, or CathPCI.*
† *For GWTG-Heart credit, hospital has to publicly report data in at least one of the following registries: AFib, Coronary Artery Disease, Heart Failure, or Resuscitation.*

Structural Measures

Structural measures of health care evaluate staff, services, equipment and other resources used to deliver care. Structural indicators that have been associated with good outcomes for patients are included. In addition to volume, six structural indicators are employed.

[13] Shahian, David M., et al. "The Society of Thoracic Surgeons voluntary public reporting initiative: the first 4 years." Annals of surgery 262.3 (2015): 526-535.

[14] Data was extracted from the STS website (https://publicreporting.sts.org/) in December, 2022 and contains information up until December 2021.

- **Volume.** There is widespread evidence that hospitals performing a procedure more frequently get better outcomes. Volume derived from Medicare claims is therefore included as an indicator. We include all visits within our analysis periods when calculating the volume measure for each cohort.

  In order to account for total knee replacement transitioning to the outpatient setting[15], we combine knee volume from the Outpatient LDS SAF with inpatient knee volume. We apply the same strategy for hip replacement, prostate cancer surgery, and uterine cancer surgery cohorts.

  Volume totals in each procedure or condition cohort are adjusted to account for Medicare Advantage (MA) cases. Hospitals with very low volumes – defined as fewer than 15 cases over five years – are not rated because their numbers are too low to establish whether the quality of care is different from average.

  In addition, in order to reduce the effect of outliers, we imposed a ceiling threshold on the volume measure. If a hospital's MA-adjusted volume corresponds to greater than modified Z-score 3, it's winsorized and replaced with the volume that corresponds to modified Z-score equals 3. The formula for the modified Z-score is $0.6745(xi - \tilde{x}) / MAD$, where:

  xi: Hospital's own value

  $\tilde{x}$: The median across all hospitals

  MAD: The median absolute deviation across all hospitals

- **Nurse staffing**. The number of nurses involved in direct patient care at a hospital is known to play a major role in the quality of care[16,17,18,19,20,21]. For this project, we conceptualize a nurse staffing index as a ratio reflecting inpatient and outpatient nursing. Nurse staffing index was calculated using AHA survey data from the most recent year available (i.e., the 2021 AHA survey database was used for the 2023-2024 publications). The numerator is the total number of staff registered nurses (RNs), converted to full-time equivalents (FTEs). For

[15] Total Knee Arthroplasty (TKA) Removal from the Medicare Inpatient-Only (IPO) List and Application of the 2-Midnight Rule. (2019, January 24). MLN Matters, SE19002.

[16] Unruh, L. (2003) Licensed Nurse Staffing and Adverse Events in Hospitals. Medical Care. 41(1) (pp142-152)

[17] Stanton MW, Rutherford MK. (2004) Hospital nurse staffing and quality of care. Agency for Healthcare Research and Quality. Research in Action Issue 14. AHRQ Pub. No. 04-0029.

[18] Spetz J, Donaldson N, Aydin C, Brown DS. (2008) How Many Nurses per Patient? Measurements of Nurse Staffing in Health Services Research. Health Services Research. 43(5) (pp1674-1692)

[19] Lankshear AJ, Sheldon TA, Maynard A. (2005) Nurse Staffing and Healthcare Outcomes. Advances in Nursing Science. 28(2) (pp163-174)

[20] Hickham DH, Severance S, Feldstein A. (2003) The Effect of Health Care Working Conditions on Patient Safety. AHRQ Evidence Report/Technology Assessment (74)

[21] Needleman J, Buerhaus P, Pankratz VS, Leibson CL, Stevens SR, Harris M. (2011) Nurse Staffing and Inpatient Hospital Mortality. New England Journal of Medicine 364(11) (pp1037-1045)

example, two half-time nurses add up to one FTE. Only non-supervisory nurses with an RN degree from an approved nursing school and a current state registration are included.

Making sense of nurse staffing requires comparing the number of staff to the total workload. The two most commonly used approaches are total patient days and adjusted average daily census of patients, and we use the latter for the composite models for the procedures and conditions ratings, as it better conceptualizes the total workload of nursing, taking into account both inpatient and outpatient revenue adjusted by the number of days that the facility is open during the reporting period. The adjusted average daily census of patients obtained from the AHA survey reflects the number of days of inpatient care plus an estimate of the volume of outpatient services, expressed in units equivalent to an inpatient day in terms of level of effort. The latter is derived by first multiplying the number of inpatient days by the ratio of outpatient revenue per outpatient visit to inpatient revenue per inpatient day (to get the number of patient days attributable to outpatient services), then adding that to the number of inpatient days. The nurse staffing ratio for each year is mathematically expressed as the following:[22]

$$\frac{\text{inpatient days} + \left(\text{inpatient days} \times \frac{\text{outpatient revenue}}{\text{inpatient revenue}}\right)}{\text{number of days in the reporting period}}$$

- The nurse staffing index is then a ratio of FTE registered nurses divided by adjusted patient days. As with volume, and using the same formula, extreme values were adjusted to reduce the influence of wide variation. **ICU specialists**. Intensivists are board-certified physicians with subspecialty or fellowship training in critical-care medicine. They specialize in managing critically ill patients in hospital intensive care units (ICUs). A hospital receives credit if it reported having at least one full-time equivalent intensivist available, on staff or from another source, in any ICU other than neonatal or pediatric. Research indicates that better outcomes are associated with the presence of intensivists.[23, 24] This measure is derived from the 2021 AHA survey. AAA, AVR, heart attack, diabetes, hip replacement, knee replacement, pneumonia, and stroke cohorts received a credit if hospitals had at least one specialized intensive-care unit physician. CABG and TAVR cohorts received a credit if hospitals had either at least one specialized intensive-care unit physician or a cardiac intensive-care unit.**Cardiac intensive care unit.** Cardiac Intensive Care Units (CICU) are specialized units that are designed to manage patients who are critically ill with serious heart conditions or who are recovering from heart surgery. Hospitals receive credit if they reported having a cardiac intensive care unit. This measure is derived from the 2021 AHA survey. In the heart failure cohort, hospitals receive a credit if they had a cardiac intensive-care unit. In the CABG and TAVR cohorts, hospitals receive a credit if they had either at least one specialized

[22] This can be found in the survey code book for the AHA annual survey.

[23] Pronovost PJ, Holzmueller CG, Clattenburg L, Berenholtz S, Martinez EA, Paz JR, Needham DM. "Team care: beyond open and closed intensive care units." *Current Opinion in Critical Care*. 2006; 12(6):604-8.

[24] Sapirstein A, Needham DM, Pronovost PJ. "24-hour intensivist staffing: balancing benefits and costs." *Critical Care Medicine*. 2008; 36(1):367-8.

intensive-care unit physician or a cardiac intensive-care unit.

- **NCI-designated Cancer Center and/or American College of Surgeons (ACS) Commission on Cancer.** In cancer surgery cohorts, this measure identifies whether a hospital is recognized as a designated cancer center by the NCI, a member of the ACS Commission on Cancer, or both. Hospitals with both received the maximum score on this measure, hospitals with neither received the minimum score, and hospitals with one organization but not the other received an intermediate score. The NCI funds clinical trials and other advances in care, and the ACS provides tools and resources to help hospitals deliver high quality, patient-centered care.

Risk-Adjustment for Medicare Claims-Based Outcomes

When comparing outcomes between hospitals, adjusting for differences in the patients treated at each hospital is critical. A hospital with a 50% mortality rate might be superior to a hospital with a 10% mortality rate if most of the patients at the first hospital are expected to die and most of the patients at the second hospital are low risk.

We use multilevel logistic regression models to adjust for differences in case mix between hospitals. Multilevel models are a form of regression that allocates variance between variables on two or more levels. We use the empirical Bayes estimate of the hospital intercept as an estimate of each hospital's value for a given outcome. Multilevel modeling accounts for clustering of patient observations within hospitals and allows for a more precise rating of hospitals with lower patient volume and fewer outcomes.

We select covariates for inclusion in risk-adjustment models based on the literature, discussions with clinicians in relevant specialties and a causal-inference model aimed at achieving unbiased estimation of the effect of treatment at a particular hospital on a given outcome.

The causal model (Appendix B) indicates that an unbiased estimate of the effect of treatment at a given hospital as compared to a hospital selected at random from among those eligible for rating in a cohort, requires adjustment for age, sex, comorbidities, severity of index condition, socioeconomic status (SES), admission urgency, inbound transfer status, and year of admission. In certain instances, we control for the severity of the index condition. Because severity is correlated with many of the other covariates for which we adjusted, we suspect residual confounding is negligible. "Strengths and Limitations" contains further discussion of this issue.

For all outcomes analyses, inbound transfers are not excluded and its status is factored into the outcomes model as a risk-adjustment. As a result, for the discharge to home outcome measures, only inpatient source admission code of 05 (transfer from a SNF or ICF) and visits that were determined to have been admissions from a SNF were excluded from the discharge to home measure definition. For medical cohorts (CHF, COPD, heart attack, stroke, pneumonia, kidney

failure, and diabetes), visits with outbound transfer status are omitted from the analyses.

Risk-Adjustment Variables

- **Age at admission**. Age in years as a continuous variable, obtained from the denominator or Master Beneficiary Summary file.
- **Sex**. Male or female.
- **Inbound transfer status.** Transfer from the initial receiving hospital may indicate a complex case. Visits are classified as an inbound transfer if the patient was treated at another acute care hospital on the day of admission, if the claim admission source variable indicates inbound transfer, or if the preceding visit indicates outbound transfer.
- **Year of hospital admission**. Quality of care tends to improve over time, so year-over-year risk of adverse outcomes should decrease.
- **Elixhauser comorbidities.** Comorbidities identified by Elixhauser et al[25] are highly predictive of mortality.[26] All 38 comorbidities identified with AHRQ's Elixhauser comorbidity software version 2022.1, released in Oct 2021, which overlaps with the study period of 2017-2021, are individually adjusted for.
- **Medicare status code**. The reason(s) why the patient is eligible for Medicare: age, disability, or end-stage renal failure. Medicare status code is conceptualized as a proxy for comorbidities.
- **Socioeconomic status**. Patients with lower incomes are typically sicker when they arrive at the hospital, and may face more challenges in obtaining or managing their care after they are discharged. This can affect their risk of death, readmission and complications. When hospitals differ by the socioeconomic status of their patients, this can create bias in comparing outcomes. Our risk-adjustment models include "dual-eligibility" as a measure of socioeconomic background, and patients who are eligible for both Medicare and Medicaid are treated as a separate risk group.
- **Condition cohort-specific covariates.** Binary variables indicating whether a patient had ever left against medical advice, been admitted for the same condition, or had a history of mechanical ventilation are included in the CHF and COPD models. Respiratory failure is risk-adjusted in COPD outcomes models. A binary measure indicating whether a patient was diagnosed with acute leukemia is included in the leukemia, lymphoma & myeloma model. A binary measure indicating whether a patient had a diagnosis of sepsis is included for the pneumonia cohort. Binary variables indicating whether a patient had a diagnosis of ST elevation myocardial infarction (STEMI) of anterior wall, STEMI of inferior wall, or non-ST elevation myocardial infarction (NSTEMI) are included in the heart attack models. Binary

[25] Elixhauser, Anne, et al. Comorbidity measures for use with administrative data. *Medical care* 36.1 (1998): 8-27.

[26] Elixhauser Comorbidity Software Refined for ICD-10-CM Healthcare Cost and Utilization Project (HCUP). October 2021. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/toolssoftware/comorbidityicd10/comorbidity_icd10.jsp.

variables indicating whether a patient was diagnosed with diabetes ketoacidosis (DKA) and hypoglycemia are included in the diabetes models. A continuous NIHSS score, and binary variables indicating whether a patient was transferred from an emergency department or had previously been diagnosed with a transient ischemic attack (TIA), are included in the stroke models. For stroke visits in which NIHSS was not recorded, it is imputed using multiple imputation, generating imputed values by fitting a linear mixed effects model with patient-level and hospital-level attributes in order to incorporate the hierarchical structure of patient-visit data.

- **Surgical cohort-specific covariates.** A binary variable indicating whether the operation was performed on both joints simultaneously (bilaterally) is included in the hip replacement and knee replacement models. A binary variable indicating approach (open or endoscopic) is included in the AAA mortality model. A binary variable indicating diagnosis of CHF or heart attack is included in the CABG models. An ordinal variable indicating the type of degenerative condition (e.g., scoliosis) is included in the back surgery models. A binary variable indicating whether a patient also had a secondary diagnosis of the other cancer is included in the ovarian and uterine models.
- **History of stroke.** A variable indicating history of stroke in the year prior to surgery is included in the stroke model for the TAVR, AVR, and CABG cohorts.
- **Covid-19 diagnosis.** Patients diagnosed with Covid-19 in 2021 (and onward) are risk-adjusted in all P&C outcomes models.

Evaluation of Risk-Adjustment Models

The accuracy of risk-adjustment models is measured by two statistics, the C-statistic and the Hosmer-Lemeshow goodness of fit statistic. The C-statistic estimates the probability that if one subject who experienced an outcome (death, for example) and another who did not are drawn randomly from the data, the model will assign a higher probability of death to the person who died. A C-statistic of .5 indicates the model has no better than random chance at predicting the outcome. A C-statistic in the .60-.69 range indicates limited discrimination, .70-.79 indicates reasonable discrimination and above .8 indicates good discrimination.

Table 4 provides the C-statistics and Hosmer-Lemeshow goodness of fit statistics of outcome analyses for all P&C cohorts. Typically, the C-statistic for mortality models implemented using clinical data range from approximately .75-.85[27]. Our models for outcomes are generally of similar predictive quality as those based on clinical data. Our models for readmission and others have lower predictive power, with C-statistics similar to those in the published literature drawing on claims data. The Hosmer-Lemeshow goodness of fit statistic looks at whether the observed number of outcomes matches the expected number predicted by the model in samples of the population. As

[27] e.g.: Kozower, Benjamin D., et al. "STS database risk models: predictors of mortality and major morbidity for lung cancer resection." *The Annals of Thoracic Surgery* 90.3 (2010): 875-883; Hamel, Mary Beth, et al. "Surgical outcomes for patients aged 80 and older: morbidity and mortality from major noncardiac surgery." *Journal of the American Geriatrics Society* 53.3 (2005): 424-429.

this test is not informative for samples over 25,000, we use a procedure designed to evaluate Hosmer-Lemeshow fit in large samples, in which multiple Hosmer-Lemeshow tests are conducted on small samples of the data. A Hosmer-Lemeshow test results in a p-value, which conventionally indicates likely bad fit when below 0.05 unlikely bad fit when closer to 1. For the stroke cohort, 10 sets of fit indices are combined together using Rubin's rule after imposing multiple imputation.[28]

[28] Rubin, D. B. (2004). Multiple imputation for nonresponse in surveys (Vol. 81). John Wiley & Sons

Table 4: *Predictive Accuracy of Risk-adjustment Models*

Cohort	Outcome	C-statistic	Mean (min, max) of Large-sample HL Tests
AAA	Survival	0.825	0.62 (0.08,0.88)
	Discharging patients directly to home	0.833	0.42 (0.07,0.83)
	Infection prevention	0.848	0.58 (0.00,0.99)
AVR	Survival	0.781	0.48 (0.04,0.97)
	Discharging patients directly to home	0.810	0.28 (0.00,0.80)
	Prevention of prolonged hospitalizations	0.796	0.46 (0.00,0.94)
	Infection prevention	0.796	0.62 (0.09,0.89)
	Prevention of stroke	0.781	0.60 (0.06,0.95)
	Readmission prevention	0.629	0.59 (0.05,0.95)
Back surgery (Spinal fusion)	Survival	0.766	0.36 (0.00,0.79)
	Giving patients time at home	0.749	0.64 (0.02,0.87)
	Readmission prevention	0.646	0.52 (0.00,0.95)
COPD	Survival	0.764	0.45 (0.02,0.85)
	Discharging patients directly to home	0.750	0.53 (0.03,0.95)
Colon cancer surgery	Survival	0.817	0.51 (0.05,0.92)
	Discharging patients directly to home	0.833	0.39 (0.01,0.92)
	Prevention of prolonged hospitalizations	0.798	0.37 (0.00,0.94)
Diabetes	Survival	0.779	0.59 (0.09,0.98)
	Discharging patients directly to home	0.738	0.31 (0.04,0.86)
Heart attack	Survival	0.808	0.57 (0.06,0.91)
	Discharging patients directly to home	0.820	0.32 (0.05,0.88)
	Readmission prevention	0.664	0.51 (0.04,0.92)
CABG	Survival	0.777	0.39 (0.05,0.93)
	Giving patients time at home	0.774	0.47 (0.02,0.94)
	Prevention of prolonged hospitalizations	0.788	0.38 (0.03,1.00)
	Infection prevention	0.824	0.51 (0.01,0.90)
	Prevention of stroke	0.738	0.49 (0.04,0.87)
	Readmission prevention	0.658	0.40 (0.00,0.97)
CHF	Survival	0.711	0.40 (0.15,0.70)
	Discharging patients directly to home	0.726	0.44 (0.04,0.85)
Hip fracture	Survival	0.770	0.44 (0.00,0.90)
	Readmission prevention	0.635	0.57 (0.17,0.99)
Hip replacement	Survival	0.822	0.70 (0.00,1.00)
	Giving patients time at home	0.785	0.56 (0.10,0.93)
	Prevention of revision surgery	0.668	0.60 (0.15,0.97)
	Infection prevention	0.768	0.56 (0.00,0.88)
	Readmission prevention	0.685	0.54 (0.22,0.86)
Kidney failure	Survival	0.771	0.36 (0.08,0.74)
	Discharging patients directly to home	0.751	0.36 (0.04,0.90)
Knee replacement	Survival	0.770	0.44 (0.00,1.00)
	Giving patients time at home	0.764	0.39 (0.04,0.84)
	Infection prevention	0.785	0.66 (0.11,1.00)
	Readmission prevention	0.674	0.55 (0.01,0.95)
Leukemia, lymphoma & myeloma	Survival	0.761	0.37 (0.07,0.93)
	Readmission prevention	0.603	0.51 (0.13,0.84)
Lung cancer surgery	Survival	0.819	0.48 (0.04,0.90)
	Discharging patients directly to home	0.824	0.43 (0.01,0.90)
	Giving patients time at home	0.703	0.57 (0.02,0.91)
	Prevention of prolonged hospitalizations	0.772	0.42 (0.06,0.97)
	Readmission prevention	0.642	0.32 (0.03,0.70)
Ovarian cancer surgery	Survival	0.857	0.54 (0.01,0.97)
	Discharging patients directly to home	0.816	0.65 (0.28,0.89)
	Prevention of prolonged hospitalizations	0.760	0.22 (0.03,0.60)
	Readmission prevention	0.660	0.44 (0.03,0.80)
Pneumonia	Survival	0.749	0.41 (0.03,0.70)
	Discharging patients directly to home	0.768	0.20 (0.01,0.85)
Prostate cancer surgery	Survival	0.893	0.61 (0.07,0.97)
	Discharging patients directly to home	0.925	0.65 (0.15,0.89)
	Prevention of prolonged hospitalizations	0.811	0.28 (0.06,0.96)
Stroke	Survival	0.883	0.41 (0.01,0.95)
	Discharging patients directly to home	0.828	0.25 (0.00,0.83)
	Giving patients time at home	0.689	0.08 (0.00,0.59)
TAVR	Survival	0.734	0.53 (0.04,0.84)
	Giving patients time at home	0.714	0.47 (0.01,0.94)
Uterine cancer surgery	Survival	0.858	0.49 (0.01,0.97)
	Discharging patients directly to home	0.845	0.34 (0.02,0.76)

Construction of Composite Ratings

There are two major issues in constructing a composite rating of quality of surgical or medical care: determining how much weight each indicator should receive and accounting for measurement error. Some approaches, such as averaging a set of indicators with equal weight on each, do not address measurement error. More sophisticated statistical procedures can determine empirically how much weight each indicator should be assigned. They can also account for the degree to which an indicator is measured inaccurately due to incomplete risk-adjustment, random variation due to low sample size, and other factors.

Best Hospitals: Procedures & Conditions relies on a statistical method known as confirmatory factor analysis, which assigns empirical weights to the indicators. This approach has been previously used to evaluate provider quality of care.[29] Confirmatory factor analysis is based on the statistical principle that variables sharing a common cause will be correlated. Here, we hypothesize that the various candidate indicators for a given condition or procedure are caused by an underlying, or latent, variable that represents quality of surgical or medical care rendered by a hospital. Thus, for each indicator, the model can estimate the extent to which the values are the result of a relationship with quality of care. The remaining variance in the indicator is attributed to measurement error. The degree to which an indicator is correlated with other indicators helps to determine its weight in the equation for the composite scores.

We develop models by evaluating model statistics for all possible combinations of a field of structure, process, and outcome indicators. From the resulting list of candidate models exhibiting acceptable fit statistics, we select final models offering an optimal combination of number of indicators (models with more indicators produce more accurate factor scores), number of outcomes, model fit, and consistency with models in related cohorts. The selected models show acceptable fit statistics in the majority of the bootstrapped samples in all cohorts.

We evaluate our confirmatory factor analysis models using three measures: the comparative fit index (CFI), the Tucker-Lewis index (TLI), and the root mean square error of approximation (RMSEA). The literature provides a variety of standards for acceptable model fit using these statistics. We seek final models with a CFI and TLI of .9 or greater, and RMSEA of .1 or lower, while also considering our theoretical understanding of the factors that are most relevant for quality of care. Most models display fit characteristics better than the cutoff values. Even if the fit indices are not optimal, the CFA model is selected if it aligns with findings from scientific literature, is informed by medical professionals, and is in line with our theoretical understanding of the quality of hospital care. **Table 5** displays fit indices for all procedures & conditions cohorts.

We estimate model fit statistics with the robust weighted least squares multivariate (WLSMV)

[29] e.g. Keller, S., A. J. O'Malley, R. D. Hays, R. A. Matthew, A. M. Zaslavsky, K. A. Hepner, and P. D. Cleary. "Methods Used to Streamline the CAHPS Hospital Survey." *Health Serv Res* 40, no. 6 Pt 2 (Dec 2005): 2057-77.

estimator after imputing missing data with relevant hospital-level characteristics. We do not assign quality scores to hospitals based on imputed data. To avoid using this imputed data for that purpose, we estimate hospital factor scores separately with the robust maximum likelihood (MLR) model using a full information maximum likelihood with empirical Bayes (FIML) estimator. This latter model is appropriate for use with missing data, but does not provide the fit statistics necessary to guide model development when categorical indicators are included. Fit statistics can change depending on the estimator used, so there is no assurance that fit estimated with WLSMV is the same as fit that would be estimated with MLR. However, we find key model results, including factor loadings, fit statistics, and factor scores, to be robust across these two estimators.[30]

We assign each rated hospital in a cohort to one of three bands: below average, average, or high performing. Inference that a hospital was below average or high performing was made at the 75% confidence level. Health researchers more commonly use a 95% confidence level, an approach that is geared toward minimizing the number of false positive results (in this context, incorrectly identifying average hospitals as below average or high performing). However, because false negatives (identifying poor-performing hospitals as average) can have serious consequences for patients, we seek to strike a balance between minimizing false positive and false negative results.

To ensure that high performing hospitals have reasonably good outcomes and do not overutilize certain services, three conditions further modify the hospital ratings. First, *if all the outcome measures in a cohort's CFA are categorized with "poor" ratings, its overall rating in that cohort is downgraded to "average" if it would otherwise be categorized as "high performing" by the CFA results alone*. For example, the diabetes cohort contains two outcome measures, survival and discharging patients directly to home. Any hospital that received "poor" ratings for both of these outcomes and "high performing" overall would have its diabetes rating downgraded to "average". As a result, 38 ratings across 5 cohorts are downgraded from "high performing" to "average".

Second, *if the CFA model includes at least two patient outcomes, and those outcomes predominantly are "poor" or "worse than average" outcomes, without including any "better than average" or "exellcent" outcomes, and if the hospital has a very high volume band, then the overall rating of that hospital in that specific cohort is downgraded to "average"*. As a result, 357 ratings across 12 cohorts are downgraded from "high performing" to "average".

Third, using ratings computed by data scientists at the Lown Institute using 2019-2021 Medicare fee-for-service claims data and 2019-2020 Medicare Advantage data, we apply downgrades in three cohorts for hospitals that receive the lowest rating in avoiding overuse in relevant procedures. Details of these measures can be found on the Lown Hospitals Index website.[31]

- For back surgery (spinal fusion), *if a hospital received a 1-star rating from the Lown Institute*

[30] When all indicators are continuous measures, the CFA with a MLR estimator yields fit statistics. Hence, for cohorts that incorporate indicators that are all continuous measures, their factor scores, fit statistics, and factor loadings are all generated using a MLR estimator.

[31] For more details, visit https://lownhospitalsindex.org

for avoiding overuse of spinal fusion/laminectomy, its U.S. News overall rating is downgraded to "average" if it would otherwise be categorized as "high performing" by the CFA results alone. As a result, 10 hospitals are downgraded from "high performing" to "average".

- For knee replacement, *if a hospital received a 1-star rating from the Lown Institute for avoiding overuse of arthroscopic knee surgery, its U.S. News overall rating is downgraded to "average" if it would otherwise be categorized as "high performing" by the CFA results alone.* As a result, 5 hospitals are downgraded from "high performing" to "average".
- For stroke, *if a hospital received a 1-star rating from the Lown Institute for avoiding overuse of carotid endarterectomy, its U.S. News overall rating is downgraded to "average" if it would otherwise be categorized as "high performing" by the CFA results alone.* As a result, 13 hospitals are downgraded from "high performing" to "average".

Indicators and Correlations With Scores

The following tables list the indicators included in each cohort's final composite model. The quality score correlation, or standardized factor loading, indicates the relative strength of the relationship in a cohort between a given indicator and hospitals' quality scores. The quality score correlation is determined by the statistical model; it is not a weight and is not applied as a factor of a summative formula. Instead, it is applied to a maximum likelihood estimation algorithm that produces the overall quality score for each hospital. The greater the value of the correlation, the stronger the relationship to the quality score. It may be noted that outcome measures in some cohorts are relatively weakly correlated with quality scores. That is to be expected if the incidence of negative outcomes is very low, as it is, for example, for mortality in the hip replacement and knee replacement cohorts, or if there is little variation in the measure from one hospital to another.

Table 5: *Confirmatory Factor Analysis Fit Statistics, by Cohort**

	CFI	TLI	RMSEA
Abdominal aortic aneurysm repair	0.94	0.91	0.05
Aortic valve surgery	0.94	0.92	0.06
Back surgery (Spinal fusion)	0.98	0.92	0.05
Chronic obstructive pulmonary disease (COPD)	0.93	0.85	0.06
Colon cancer surgery	0.99	0.98	0.10
Diabetes	0.99	0.98	0.08
Heart attack	1.00	0.99	0.09
Heart bypass surgery	1.00	0.99	0.06
Heart failure	1.00	1.00	0.10
Hip fracture	0.98	0.94	0.02
Hip replacement	1.00	1.00	0.10
Kidney failure	0.98	0.95	0.05
Knee replacement	1.00	1.00	0.10
Leukemia, lymphoma & myeloma	0.98	0.96	0.11
Lung cancer surgery	0.95	0.94	0.09
Ovarian cancer surgery	0.93	0.90	0.07
Pneumonia	0.94	0.90	0.06
Prostate cancer surgery	0.98	0.97	0.07
Stroke	1.00	1.00	0.14
Transcatheter aortic valve replacement (TAVR)	1.00	1.00	0.09
Uterine cancer surgery	0.96	0.94	0.07

* *Fit statistics are rounded to the second decimal place, for all P&C cohorts.*

Table 6: *Indicator Correlations, Abdominal Aortic Aneurysm Repair*

Indicator	Quality Correlation
Survival	0.143
Discharging patients directly to home	0.100
Infection prevention	0.106
ICU specialists	0.544
Number of patients	0.477
Nurse staffing	0.293
Worker influenza immunization	0.328

Table 7: *Hospital Distribution by Performance Band, Abdominal Aortic Aneurysm Repair*

Band	Description	Number of Hospitals
1	Below average	109
2	Average	975
3	High performing	123

Table 8: *Indicator Correlations, Aortic Valve Surgery*

Indicator	Quality Correlation
Survival	0.429
Discharging patients directly to home	0.284
Prevention of prolonged hospitalizations	0.318
Readmission prevention	0.247
Infection prevention	0.129
Prevention of stroke	0.091
ICU specialists	0.398
Number of patients	0.649
Patient experience	0.402
ACSD score	0.324

Table 9: *Hospital Distribution by Performance Band, Aortic Valve Surgery*

Band	Description	Number of Hospitals
1	Below average	133
2	Average	506
3	High performing	154

Table 10: *Indicator Correlations, Back Surgery (Spinal Fusion)*

Indicator	Quality Correlation
Survival	0.256
Giving patients time at home	0.584
Readmission prevention	0.561
Patient experience	0.255

Table 11: *Hospital Distribution by Performance Band, Back Surgery (Spinal Fusion)*

Band	Description	Number of Hospitals
1	Below average	219
2	Average	1,275
3	High performing	231

Table 12: *Indicator Correlations, Chronic Obstructive Pulmonary Disease (COPD)*

Indicator	Quality Correlation
Survival	0.375
Discharging patients directly to home	0.659
Noninvasive breathing aid	0.306
Number of patients	0.473
Nurse staffing	0.291

Table 13: *Hospital Distribution by Performance Band, Chronic Obstructive Pulmonary Disease (COPD)*

Band	Description	Number of Hospitals
1	Below average	677
2	Average	2,722
3	High performing	664

Table 14: *Indicator Correlations, Colon Cancer Surgery*

Indicator	Quality Correlation
Survival	0.421
Discharging patients directly to home	0.350
Prevention of prolonged hospitalizations	0.221
Prevention of unplanned visits after colonoscopy	0.146
Prevention of ER visits after chemotherapy	0.312
NCI and/or ACS cancer center	0.696
Number of patients	0.728
Nurse staffing	0.359

Table 15: *Hospital Distribution by Performance Band, Colon Cancer Surgery*

Band	Description	Number of Hospitals
1	Below average	591
2	Average	1,206
3	High performing	469

Table 16: *Indicator Correlations, Diabetes*

Indicator	Quality Correlation
Survival	0.221
Discharging patients directly to home	0.218
ICU specialists	0.685
Number of patients	0.710
Nurse staffing	0.322

Table 17: *Hospital Distribution by Performance Band, Diabetes*

Band	Description	Number of Hospitals
1	Below average	694
2	Average	1,611
3	High performing	552

Table 18: *Indicator Correlations, Heart Attack*

Indicator	Quality Correlation
Survival	0.542
Discharging patients directly to home	0.484
Readmission prevention	0.085
ACC or GWTG Heart registry participation	0.705
ICU specialists	0.521
Number of patients	0.775
Nurse staffing	0.331
Patient experience	0.075

Table 19: *Hospital Distribution by Performance Band, Heart Attack*

Band	Description	Number of Hospitals
1	Below average	805
2	Average	963
3	High performing	873

Table 20: *Indicator Correlations, Heart Bypass Surgery*

Indicator	Quality Correlation
Survival	0.620
Giving patients time at home	0.510
Prevention of prolonged hospitalizations	0.224
Readmission prevention	0.396
Infection prevention	0.124
Prevention of stroke	0.167
Cardiac ICU or ICU specialists	0.522
Number of patients	0.586
Nurse staffing	0.337
Worker influenza immunization	0.192
ACSD score	0.435

Table 21: *Hospital Distribution by Performance Band, Heart Bypass Surgery*

Band	Description	Number of Hospitals
1	Below average	255
2	Average	551
3	High performing	237

Table 22: *Indicator Correlations, Heart Failure*

Indicator	Quality Correlation
Survival	0.451
Discharging patients directly to home	0.518
GWTG Heart registry participation	0.597
Cardiac ICU	0.769
Noninvasive breathing aid (≥20%)	0.682
Number of patients	0.809
Nurse staffing	0.350

Table 23: *Hospital Distribution by Performance Band, Heart Failure*

Band	Description	Number of Hospitals
1	Below average	1,316
2	Average	1,666
3	High performing	1,090

Table 24: *Indicator Correlations, Hip Fracture*

Indicator	Quality Correlation
Survival	0.492
Readmission prevention	0.151
Board certified physicians	0.088
Nurse staffing	0.345

Table 25: *Hospital Distribution by Performance Band, Hip Fracture*

Band	Description	Number of Hospitals
1	Below average	118
2	Average	2,674
3	High performing	172

Table 26: *Indicator Correlations, Hip Replacement*

Indicator	Quality Correlation
Survival	0.194
Giving patients time at home	0.587
Readmission prevention	0.517
Prevention of revision surgery	0.399
Infection prevention	0.332
Board certified physicians	0.099
ICU specialists	0.310
Number of patients (includes outpatient setting)	0.626
Nurse staffing	0.241
Patient experience	0.238

Table 27: *Hospital Distribution by Performance Band, Hip Replacement*

Band	Description	Number of Hospitals
1	Below average	573
2	Average	1,493
3	High performing	570

Table 28: *Indicator Correlations, Kidney Failure*

Indicator	Quality Correlation
Survival	0.543
Discharging patients directly to home	0.521
Number of patients	0.546
Nurse staffing	0.398

Table 29: *Hospital Distribution by Performance Band, Kidney Failure*

Band	Description	Number of Hospitals
1	Below average	603
2	Average	2,316
3	High performing	590

Table 30: *Indicator Correlations, Knee Replacement*

Indicator	Quality Correlation
Survival	0.145
Giving patients time at home	0.487
Readmission prevention	0.294
Infection prevention	0.277
ICU specialists	0.403
Number of patients (includes outpatient setting)	0.693
Nurse staffing	0.284
Patient experience	0.241

Table 31: *Hospital Distribution by Performance Band, Knee Replacement*

Band	Description	Number of Hospitals
1	Below average	562
2	Average	1,714
3	High performing	646

Table 32: *Indicator Correlations, Leukemia, Lymphoma & Myeloma*

Indicator	Quality Correlation
Survival	0.456
Readmission prevention	0.088
NCI and/or ACS cancer center	0.718
Number of patients	0.697
Nurse staffing	0.437
Patient experience	0.428
Worker influenza immunization	0.196

Table 33: *Hospital Distribution by Performance Band, Leukemia, Lymphoma & Myeloma*

Band	Description	Number of Hospitals
1	Below average	436
2	Average	1,039
3	High performing	351

Table 34: *Indicator Correlations, Lung Cancer Surgery*

Indicator	Quality Correlation
Survival	0.437
Discharging patients directly to home	0.501
Giving patients time at home	0.413
Prevention of prolonged hospitalizations	0.606
Readmission prevention	0.165
Prevention of ER visits after chemotherapy	0.271
NCI and/or ACS cancer center	0.537
Number of patients	0.696
Nurse staffing	0.393
Public transparency	0.731

Table 35: *Hospital Distribution by Performance Band, Lung Cancer Surgery*

Band	Description	Number of Hospitals
1	Below average	276
2	Average	507
3	High performing	254

Table 36: *Indicator Correlations, Ovarian Cancer Surgery*

Indicator	Quality Correlation
Survival	0.401
Discharging patients directly to home	0.269
Prevention of prolonged hospitalizations	0.214
Readmission prevention	0.184
Prevention of ER visits after chemotherapy	0.151
NCI and/or ACS cancer center	0.682
Number of patients	0.585
Nurse staffing	0.407
Worker influenza immunization	0.223

Table 37: *Hospital Distribution by Performance Band, Ovarian Cancer Surgery*

Band	Description	Number of Hospitals
1	Below average	70
2	Average	317
3	High performing	74

Table 38: *Indicator Correlations, Pneumonia*

Indicator	Quality Correlation
Survival	0.411
Discharging patients directly to home	0.544
Compliance with septic shock bundle	0.205
ICU specialists	0.703
Nurse staffing	0.376
Worker influenza immunization	0.139

Table 39: *Hospital Distribution by Performance Band, Pneumonia*

Band	Description	Number of Hospitals
1	Below average	686
2	Average	2,797
3	High performing	718

Table 40: *Indicator Correlations, Prostate Cancer Surgery*

Indicator	Quality Correlation
Survival	0.252
Discharging patients directly to home	0.140
Prevention of prolonged hospitalizations	0.425
Prevention of ER visits after chemotherapy	0.166
NCI and/or ACS cancer center	0.525
Number of patients (includes outpatient setting)	0.677
Nurse staffing	0.396
Patient experience	0.446

Table 41: *Hospital Distribution by Performance Band, Prostate Cancer Surgery*

Band	Description	Number of Hospitals
1	Below average	228
2	Average	641
3	High performing	252

Table 42: *Indicator Correlations, Stroke*

Indicator	Quality Correlation
Survival	0.383
Discharging patients directly to home	0.581
Giving patients time at home	0.213
GWTG Stroke registry participation	0.726
Number of patients	0.811
Nurse staffing	0.325

Table 43: *Hospital Distribution by Performance Band, Stroke*

Band	Description	Number of Hospitals
1	Below average	1,116
2	Average	1,062
3	High performing	1,047

Table 44: *Indicator Correlations, Transcatheter Aortic Valve Surgery*

Indicator	Quality Correlation
Survival	0.403
Giving patients time at home	0.126
Cardiac ICU or ICU specialists	0.550
Number of patients	0.523
Nurse staffing	0.462
Patient experience	0.533
Public transparency	0.488
Worker influenza immunization	0.327

Table 45: *Hospital Distribution by Performance Band, Transcatheter Aortic Valve Surgery*

Band	Description	Number of Hospitals
1	Below average	147
2	Average	490
3	High performing	112

Table 46: *Indicator Correlations, Uterine Cancer Surgery*

Indicator	Quality Correlation
Survival	0.111
Discharging patients directly to home	0.135
Prevention of ER visits after chemotherapy	0.137
NCI and/or ACS cancer center	0.820
Number of patients (includes outpatient setting)	0.435
Nurse staffing	0.363
Worker influenza immunization	0.327

Table 47: *Hospital Distribution by Performance Band, Uterine Cancer Surgery*

Band	Description	Number of Hospitals
1	Below average	89
2	Average	359
3	High performing	69

Validation of Procedures & Conditions Ratings

The primary means of evaluating construct validity of our measurement models and resulting factor scores is a multi-trait matrix, by which we compare the relative correlations of hospital ratings across cohorts. Specifically, we hypothesize that hospital factor scores for heart bypass surgery, aortic valve surgery, and TAVR would be more closely correlated with each other than with the other procedure cohorts, and that the two cardiac surgeries would be least correlated with the condition cohorts. Similarly, we hypothesize that hip replacement and knee replacement ratings would be highly intercorrelated, and less well correlated with other procedures, and that they, like the cardiac surgeries, would be least correlated with condition cohorts. Finally we hypothesize that factor scores among condition cohorts would be strongly intercorrelated, and less well correlated with procedure ratings. The correlations align with our expectations, and they provide strong evidence of construct validity. We also hypothesize that hospitals who are ranked (i.e. perform extremely well) in specialty care would more often be rated high performing in related P&C cohorts.

We further investigate validity by examining concordance of the CABG and AVR ratings with ratings published by STS. The U.S. News and STS ratings cover different time periods and patient populations. The U.S. News ratings are based on three domains of quality, while the STS ratings do not use structural indicators. The U.S. News ratings employ statistical testing at the $p<.25$ level, while STS ratings employ a standard of $p<.05$, and because of this difference, one would expect that the U.S. News ratings would identify more hospitals as performing above or below average. We hypothesize modest agreement between the two sets of ratings, with very few instances of marked disagreement, in which a hospital received the lowest rating from one organization and the highest from the other. **Table 48** and **Table 49** show findings consistent with this hypothesis.

Table 48: *Concordance with STS ACSD Aortic Valve Surgery Star Rating*

	ACSD Star Rating		
	1	2	3
Below Average	1	39	0
Average	2	352	6
High Performing	0	108	28

Table 49: *Concordance with STS ACSD Heart Bypass Surgery Star Rating*

	ACSD Star Rating		
	1	2	3
Below Average	22	60	3
Average	34	286	48
High Performing	2	106	117

To ensure the validity of our newly added leukemia, lymphoma & myeloma ratings we compare them with external cancer accreditations. The national cancer institute (NCI) recognizes centers across the country that are focused on advancing research into the prevention, diagnosis and treatment of cancer. Similarly, the Foundation for the Accreditation of Cellular Therapy (FACT) provides accreditation to organizations that meet rigorous standards for the use of cellular therapies, many of which have become standard in the treatment of certain blood cancers. We hypothesize that hospitals that have achieved these external accreditations will perform better in our ratings relative to hospitals without them. This is confirmed by the results in Table 50 below where we see that all hospitals associated with an NCI-designated cancer center and the vast majority with FACT accreditation are rated as high performing.

Table 50: *Leukemia, Lymphoma & Myeloma Ratings and Cancer Accreditations*

	NCI-Designated Cancer Center*		FACT Accreditation†	
	No	Yes	No	Yes
Below Average	436	0	435	1
Average	1039	0	1029	10
High Performing	275	76	216	135

* *Hospitals must be designated NCI clinical or comprehensive cancer centers as of 2/2/2023.*
† *Hospitals must have received FACT accreditation as of 1/27/2023.*

We further evaluate the validity of the stroke ratings. Here, we evaluate the results of outcomes models, with or without stroke severity risk adjustment. The NIHSS score, which quantifies stroke severity on a numeric scale from 0 to 42, is widely used for risk-adjustment. Studies demonstrate that the NIHSS score has a strong association with patient condition, and potentially could improve model discrimination and performance.[32] Indeed, **Table 51** shows that the inclusion

[32] Fonarow, G. C., Pan, W., Saver, J. L., Smith, E. E., Reeves, M. J., Broderick, J. P., Kleindorfer, D. O., Sacco, R. L., Olson, D. M., Hernandez, A. F., Peterson, E. D., & Schwamm, L. H. (2012). Comparison of 30-day mortality models for profiling hospital performance in acute ischemic stroke with vs without adjustment for stroke severity. JAMA, 308(3),

of a NIHSS score covariate improved model fit appreciably.

One challenge is the scarcity of the NIHSS score in claims data. Among all ischemic stroke visits between 2017 to 2021, only about 61.3% document this score. Our examination of claims data suggests that the availability of the NIHSS score is highly associated with hospital-, patient-, and visit-level attributes; in other words, the reasons for missing data are not completely random and cannot be ignored. Consequently, analyses based on complete cases or case-wise deletion may cause substantial bias. We instead choose to impute the missing NIHSS score, generating imputed values by fitting a hierarchical linear regression with hospital-level random effects. This modeling strategy is considered a superior strategy for handling missing data.[33]

Table 51: *C-statistics of Stroke Risk Models*

Outcome	w/o NIHSS risk adjustment	w/ NIHSS risk adjustment
Survival	0.79	0.88
Discharging patients directly to home	0.80	0.83
Giving patients time at home	0.68	0.69

Studies demonstrate that reperfusion therapy, including intravenous tissue plasminogen activator and mechanical thrombectomy, can improve short-term and long-term outcomes, such as reduced mortality and the incidence of hemorrhage, and an increased likelihood of patients being discharged to home when used in accordance with guidelines[34,35,36,37]. We calculate the percentage of

257–264. https://doi.org/10.1001/jama.2012.7870

[33] Lall, R. (2017). How Multiple Imputation Makes a Difference. Political Analysis, 24(4), 414-433. doi:10.1093/pan/mpw020

[34] Fonarow, G. C., Zhao, X., Smith, E. E., Saver, J. L., Reeves, M. J., Bhatt, D. L., Xian, Y., Hernandez, A. F., Peterson, E. D., & Schwamm, L. H. (2014). Door-to-needle times for tissue plasminogen activator administration and clinical outcomes in acute ischemic stroke before and after a quality improvement initiative. JAMA, 311(16), 1632–1640. https://doi.org/10.1001/jama.2014.3203

[35] Saver, J. L., Goyal, M., van der Lugt, A., Menon, B. K., Majoie, C. B., Dippel, D. W., Campbell, B. C., Nogueira, R. G., Demchuk, A. M., Tomasello, A., Cardona, P., Devlin, T. G., Frei, D. F., du Mesnil de Rochemont, R., Berkhemer, O. A., Jovin, T. G., Siddiqui, A. H., van Zwam, W. H., Davis, S. M., Castaño, C., … HERMES Collaborators (2016). Time to Treatment With Endovascular Thrombectomy and Outcomes From Ischemic Stroke: A Meta-analysis. JAMA, 316(12), 1279–1288. https://doi.org/10.1001/jama.2016.13647

[36] Powers, W. J., Rabinstein, A. A., Ackerson, T., Adeoye, O. M., Bambakidis, N. C., Becker, K., Biller, J., Brown, M., Demaerschalk, B. M., Hoh, B., Jauch, E. C., Kidwell, C. S., Leslie-Mazwi, T. M., Ovbiagele, B., Scott, P. A., Sheth, K. N., Southerland, A. M., Summers, D. V., & Tirschwell, D. L. (2019). Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. Stroke, 50(12), e344–e418. https://doi.org/10.1161/STR.0000000000000211

[37] Saver, J. L., Fonarow, G. C., Smith, E. E., Reeves, M. J., Grau-Sepulveda, M. V., Pan, W., Olson, D. M., Hernandez, A. F., Peterson, E. D., & Schwamm, L. H. (2013). Time to treatment with intravenous tissue plasminogen activator and outcome from acute ischemic stroke. JAMA, 309(23), 2480–2488. https://doi.org/10.1001/jama.2013.6959

ischemic stroke patients treated with reperfusion therapy, either with intravenous tissue plasminogen activator or mechanical thrombectomy to examine the relationship between the stroke ratings and use of reperfusion therapy. ICD-10 codes of alteplase administration or mechanical thrombectomy among all ischemic stroke patients quantify how often the hospital provided time-sensitive medical interventions. HCPCS codes denoting reperfusion therapy identify cases in which therapy was provided in an outpatient setting (i.e., emergency department) prior to inpatient admission. Table 52 shows the rate of reperfusion therapy is higher among hospitals rated as high performing compared with hospitals rated as average or below average. We see that hospitals that are rated as high performing in stroke ratings tend to provide more time-sensitive medical intervention, such as intravenous tissue plasminogen activator or mechanical thrombectomy.

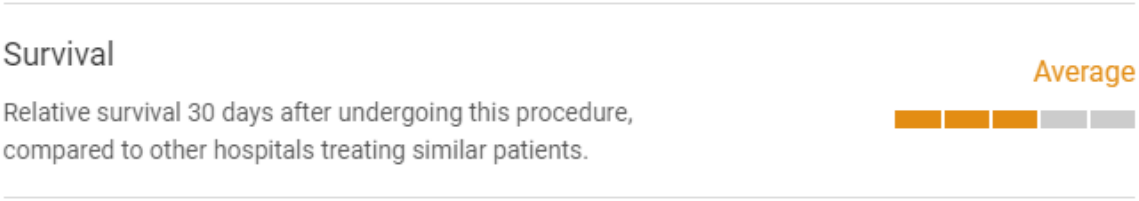
Table 52: *Rate of Reperfusion Therapies by Stroke Ratings*

	Rate of tPA*	Rate of MT†	Rate of tPA or MT‡
Below Average	0.0000	0.0000	0.0000
Average	0.0495	0.0000	0.0497
High Performing	0.0991	0.0155	0.1235

* *Cell values denote the median rate of the tissue plasminogen activator (tPA) treatment at the hospital-level.*
† *Cell values denote the median rate of the mechanical thrombectomy (MT) at the hospital-level.*
‡ *Cell values denote the median rate of the reperfusion therapy (either tissue plasminogen activator treatment or mechanical thrombectomy) at the hospital-level.*

Categorical Display

In our confirmatory factor analysis, we use the continuous form of each measure when possible. For the purpose of making information more accessible for patients, we display categorical groupings (bands) and descriptions of each continuous outcome or process measure on scorecards. See an example of the survival rating below.



Our approach to estimating each hospital's outcome band falls under the general rubric of statistical significance testing. The band cutoffs are ***different for each hospital and each measure***. This band is reflective of a hospital's estimated risk-adjusted value on the outcome compared to other hospitals, as well as its Medicare claims volume and the incidence of that outcome. We compare each hospital's risk-adjusted outcome value to a normal distribution, taking into account both the point estimate and the precision—the greater a hospital's volume, the more certain we are

of its estimated outcome value. For rare outcomes, such as death after knee replacement, relatively few hospitals have a rate designating it as above average. The bands displayed provide a heuristic for each underlying continuous metric we use to evaluate a hospital's performance.

Strengths and Limitations

Our study makes use of many data sets, which allow us to consider indicators from most, if not all, domains relevant to hospital quality measurement. We employ statistical procedures that simultaneously minimize measurement error and empirically combine indicators to maximize quality measurement validity. We conduct extensive research on the validity of our results, including using multitrait matrices and comparing with external data sets, and we benefit from input from diverse stakeholders, including patients, health service researchers, clinicians, and hospital leaders.

Quality measurement derived from the Medicare population is generally believed to be representative of what would emerge from the overall population, and affords sufficient statistical power to distinguish between providers, even when procedures may be relatively rare. The LDS SAF data imperfectly mirror the overall hospital inpatient population because, other than those with disabilities or end-stage kidney disease, Medicare members in the analysis are age 65 and older. However, these data are widely used in academic literature to permit meaningful comparisons of rates of death, complications, readmission, infection and other outcomes on a like-to-like basis across most hospitals. How these older patients fare represents a test of hospital performance that is more revealing than results would be from a population that includes younger and healthier patients. Broad "all-payer" data that would permit such an evaluation for all hospitals, moreover, is unavailable, and the population tracked is large and clearly defined.

A noteworthy limitation of the ratings is that the outcome indicators rely on administrative data, which could lead to bias in several ways. As previously discussed, controlling for severity of the index condition is required to achieve adequate case-mix adjustment. We believe we have largely mitigated this problem by adjusting for a number of variables that are correlated with severity of the index condition, such as transfer status and urgency of admission, and by using other statistical procedures that account for measurement error. It is possible, however, that our results are biased by residual confounding. Similarly, ascertainment of some outcomes, e.g. stroke or surgical-site infection, requires accurate coding across hospitals.[38] Prior studies have demonstrated, for example, that capturing stroke with different coding algorithms in administrative data results in a tradeoff between sensitivity and specificity.[39] Differences in claims coding practices could result in bias.

Another issue is our use of data sets with incomplete hospital-level data. Some of the

[38] Calderwood, M. S., A. Ma, Y. M. Khan, M. A. Olsen, D. W. Bratzler, D. S. Yokoe, D. C. Hooper, et al. "Use of Medicare Diagnosis and Procedure Codes to Improve Detection of Surgical Site Infections Following Hip Arthroplasty, Knee Arthroplasty, and Vascular Surgery." Infect Control Hosp Epidemiol 33, no. 1 (Jan 2012): 40-9.

[39] Tirschwell DL, Longstreth WT Jr. Validating administrative data in stroke research. Stroke. 2002; 33(10): 2465-2470. doi:10.1161/01.str.0000032240.28636.bd

reported data sets may have robust data for hospitals participating in the related programs, but only have a limited set of hospitals participating (or with data made available). Not all hospitals, for example, report process-of-care measures via Care Compare. We use two methods to deal with incomplete data. To build and evaluate composite models, we imputed data for missing indicators. To calculate factor scores, we relied on a FIML estimator. Both of these approaches assume that the data are missing at random. If the data are missing dependent on values of the process measures themselves, or on other unmeasured variables, the missing data could result in biased estimates. There is no way to guarantee that this assumption has not been violated. However, we determined that missing Care Compare process measures are primarily associated with hospital size, so we do not suspect that the data are missing conditional on levels of the process variables. As discussed earlier, the use of different estimators in our CFA may each result in different estimation of factor scores and fit statistics, but we found loading coefficients to be similar for the two estimators.

The statistical procedures used to estimate composite scores cannot assure that the label a researcher applies to the composite score (quality of care, in this case), is in fact germane to the content of the score itself. The factor scores we estimated might measure a latent variable different from the one we sought to measure. We addressed this possibility through extensive evaluation of construct validity. As illustrated above, those efforts were strongly supportive of our conceptualization of the factor scores as a measure of hospital quality.

Future Opportunities

Like healthcare delivery itself, quality measurement warrants continuous improvement. Among the opportunities we recognize to improve this methodology, those that stand out include: further incorporation of outpatient claims data, particularly for patient populations who may be treated in either inpatient or outpatient settings; analysis of additional procedures and conditions, to provide decision support to more patients; and the development of additional candidate measures, including a larger portfolio of risk-adjusted outcome measures and additional measures of process, appropriateness and value. In addition, U.S. News recognizes that racial and socioeconomic disparities plague the healthcare system in this country, and acknowledges the importance of addressing the role these disparities play in outcomes of care. We have begun to measure and publicly report on health equity at the hospital level.

Best Regional Hospitals

U.S. News first published Best Regional Hospitals in 2011 to offer patients a heuristic comparison of community hospitals located in or near the community where they reside. A goal of Best Regional Hospitals is to help healthcare consumers identify suitable hospitals without necessitating travel. A Best Regional Hospital is a hospital that offers a full range of services (as opposed to a specialty hospital) and that either is nationally ranked in one of the eleven data-driven Best Hospitals specialties (excluding rehabilitation) or has seven or more ratings of high performing in the Best Hospitals procedures and conditions. Note that high performing recognitions in the specialties are not counted toward the required minimum; in our view, a hospital must perform at a high level in a variety of common procedures and conditions in order to warrant recognition as one of the best hospitals in its state or metro area. In addition to the aforementioned eligibility criteria, a hospital must also have at least three more high performing procedures or conditions than below average procedures or conditions in order to be a Best Regional Hospital.

In a given state or metro area, a hospital on the Best Hospitals Honor Roll outranks all other hospitals not on the Honor Roll, regardless of point totals. Other hospitals located in each region are ranked according to the number of points they earn: Hospitals earn two points for each of the eleven data-driven Best Hospitals specialties (excluding rehabilitation) in which they are nationally ranked and one point for each specialty and each of the twenty-one procedures and conditions in which they are rated high performing. In addition, hospitals lose one point for each procedure or condition in which they were rated below average. A combined score for the AVR and TAVR procedures is used rather than assigning points for each individually, because these procedures are different approaches to treating the same disease. Similarly, a combined score for the ovarian and uterine cancer surgery procedures is used rather than assigning points for each individually. In order to be considered high performing for the combined score, a hospital has to be high performing in at least one of the procedures and at least average in the other. If a hospital only provides one of the two procedures, its score for that procedure is used.

Best Regional Hospitals eligibility details are outlined in Appendix C, while scoring details are outlined in Appendix D.

Geographical Definitions

Regional rankings are displayed for every state and for the 102 metro areas with the largest populations in the 2020 census, provided there is at least one Best Regional Hospital located in the state or metro area. In 2023-2024, 484 hospitals are recognized as Best Regional Hospitals. In all, hospitals are ranked in 94 metro areas.

U.S. News generally uses the U.S. Census Bureau list of Metropolitan Statistical Areas (MSAs) to define metro areas, but we depart from MSAs in cases where we use larger Combined Statistical Areas (CSAs) or combined adjacent MSAs to include nearby smaller cities with nationally ranked hospitals. For example, we use the Detroit CSA instead of the Detroit MSA; we use the

Denver CSA instead of the Denver MSA; we combine the Durham-Chapel Hill and Raleigh-Cary MSAs to define the Raleigh-Durham metro area; we combine the Ogden-Clearfield and Salt Lake City MSAs to define the Salt Lake City metro area; and we combine the Winston-Salem and Greensboro-High Point MSAs to define the Greensboro/Winston-Salem metro area.

Some metropolitan areas, such as Cincinnati and New York City, cross state lines. That is also true for Washington, D.C., which is included in Best Regional Hospitals as a metro area (encompassing parts of Maryland and Virginia) but not a state. Rankings are not published for U.S. territories.

U.S. News groups counties and county equivalents, like parishes, into approximately 200 regions that reflect geography, local customs, and regional health care markets. Best Regional Hospitals are recognized but not numerically ranked in regions that are not major metro areas.

Appendix A: Discharge to a location other than home

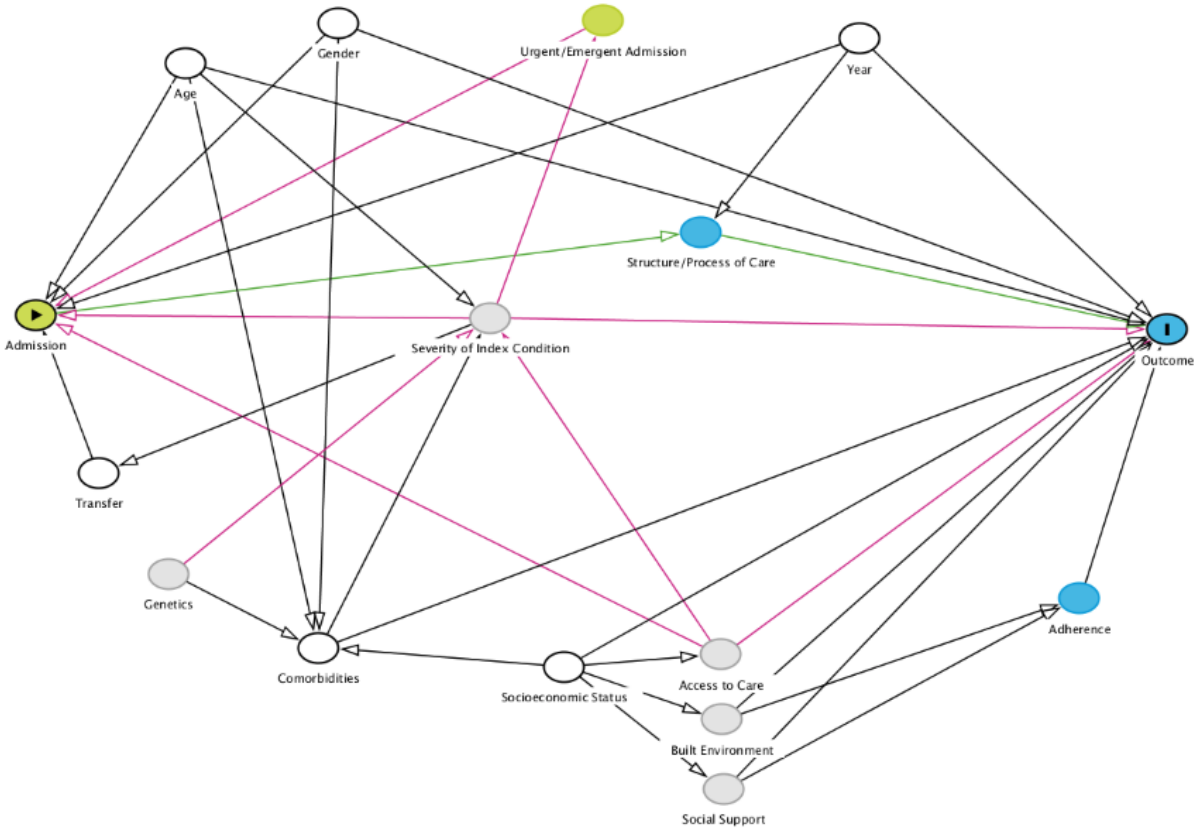
The denominator for this measure includes only patients who were discharged following a visit qualifying as an index visit in one of the 21 Procedures and Conditions cohorts. Discharge status codes of 07 (left against medical advice or discontinued care), 20 (expired, did not recover - Christian Science), 21 (court/law enforcement), 30 (still a patient), 40 (expired at home, hospice claim), 41 (expired in facility, hospice claim), 42 (expired place unknown, hospice claim), 50 (hospice – home), 62 (discharged/transferred to an IRF including distinct parts units of a hospital) or 87 (to court/law enforcement with a planned acute care hospital inpatient readmission) are excluded, as are visits with a missing or invalid discharge status code. Similarly, visits with an inpatient source admission code of 05 (transfer from a SNF or ICF) and 08 (court/law enforcement) are also excluded. Similarly, visits that are determined to have been admissions from a SNF, because in Medicare SNF claims data, the patient was observed in a SNF immediately prior to being admitted to a hospital, are excluded.

Discharge to a location other than home is indicated by one of the following patient discharge status codes: 02, 03, 04, 05, 09, 43, 51, 61, 63, 64, 65, 66, 69, 70, 82, 83, 84, 85, 88, 89, 90, 91, 92, 93, 94, 95.

Discharge codes 01 (home/self care), 06 (home with care of organized home health service organization), 81 (home/self care with planned readmission), and 86 (home with care of organized home health service organization with planned readmission) are included as a successful discharge directly to home.

APPENDIX B: CAUSAL MODEL FOR RISK-ADJUSTMENT

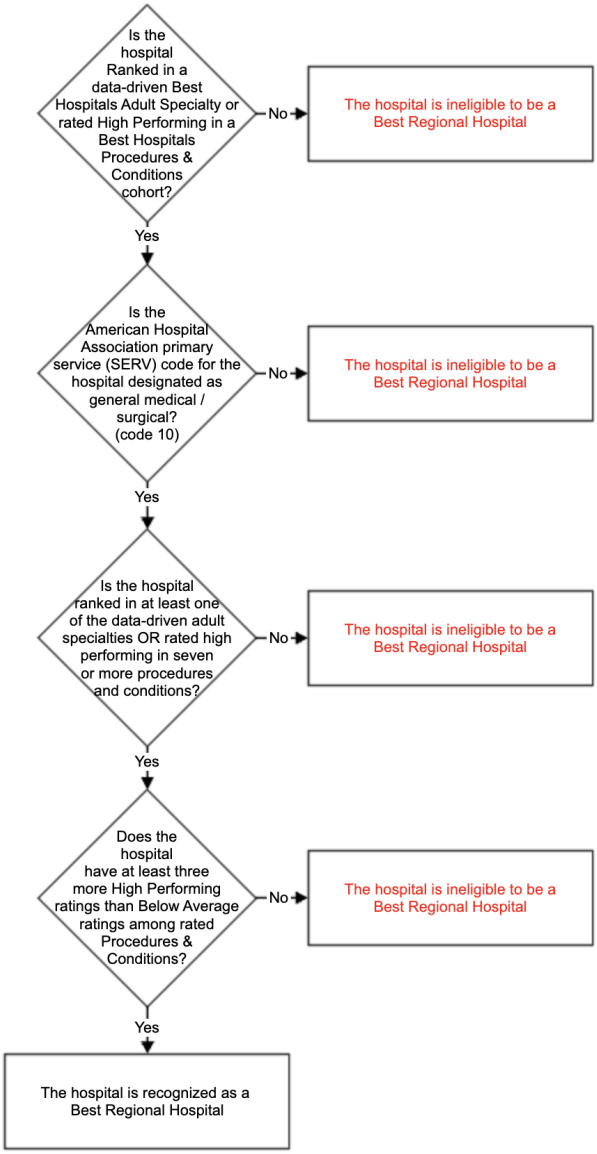
The following directed acyclic graph[40] shows the hypothesized relationship between covariates, hospital selection and outcomes.



[40] Johannes Textor, Juliane Hardt, and Sven Knuppel. Dagitty: A graphical tool for analyzing causal diagrams. Epidemiology, 22(5):745, 2011.

APPENDIX C: BEST REGIONAL HOSPITALS

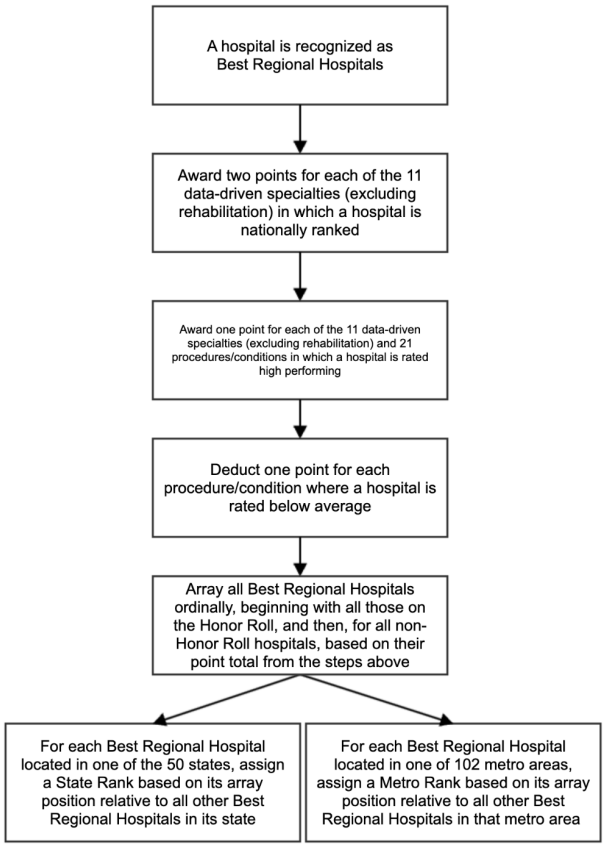
The following diagram outlines the guidelines that determine whether or not a hospital is recognized as a Best Regional Hospital.



Note:
For eligibility and scoring purposes here, the TAVR and AVR cohorts in Best Hospitals Procedures & Conditions were combined into a single cohort. Similarly, the uterine and ovarian cancer surgery cohorts were combined. Therefore, despite there being 21 Procedures & Conditions cohorts, a hospital was effectively scored in 19 for Best Regional Hospitals.
A hospital rated High Performing in both individual cohorts or rated High Performing in one and Average in the other received a High Performing rating in the combined cohort.
A hospital rated Below Average in both individual cohorts or Below Average in one and Average in the other received a Below Average rating in the combined cohort.
A hospital receiving a rating in only one of the individual cohorts received the single cohort rating for the combined cohort.

APPENDIX D: CALCULATION OF STATE AND METRO RANKINGS

The following diagram outlines the scoring methodology that determines the state and metro area rankings of Best Regional Hospitals.



Notes:

1. Point counts here were not used to determine which hospitals are Best Regional Hospitals, only to determine rank ordering of Best Regional Hospitals within a state or metro area.
2. For eligibility and scoring purposes here, the TAVR and AVR cohorts in Best Hospitals Procedures & Conditions were combined into a single cohort. Similarly, the uterine and ovarian cancer surgery cohorts were combined. Therefore, despite there being 21 procedures & conditions cohorts, a hospital was effectively scored in 19.

A hospital rated high performing in both individual cohorts or rated high performing in one and average in the other received a high performing rating in the combined cohort.

A hospital rated below average in both individual cohorts or below average in one and average in the other received a below average rating in the combined cohort.

A hospital receiving a rating in only one of the individual cohorts received the single cohort rating for the combined cohort.

Appendix E: Study Periods for Key Indicators and Cohorts

Outcome Measures		
Indicator	**Source File**	**Time Period**
Survival	Inpatient LDS SAF	11/30/2016 - 12/1/2021
Readmission prevention	Inpatient LDS SAF	11/30/2016 - 12/1/2021
Infection prevention	Inpatient LDS SAF	12/31/2015 - 12/31/2020 for hip replacement and knee replacement; 10/31/2016 - 11/1/2021 for AAA, CABG, and AVR
Prevention of revision surgery	Inpatient LDS SAF	12/31/2015 - 12/31/2020 for hip replacement and knee replacement
Prevention of prolonged hospitalization	Inpatient LDS SAF	11/30/2016 - 12/1/2021 for procedure cohorts (AAA, AVR, back surgery (spinal fusion), colon cancer surgery, CABG, hip fracture, hip replacement, knee replacement, ovarian cancer surgery, lung cancer surgery, prostate cancer surgery, TAVR,

		and uterine cancer surgery) and leukemia, lymphoma & myeloma
Discharging patients directly home	Inpatient LDS SAF; Skilled Nursing LDS SAF	12/30/2016 - 12/31/2021
Prevention of stroke	Inpatient LDS SAF	12/30/2016 - 12/31/2021 for CABG, AVR, and TAVR
Giving patients time at home	Inpatient LDS SAF; Outpatient LDS SAF; Skilled Nursing LDS SAF	11/30/2016-12/1/2021
Process Measures		
Worker flu immunization	CMS Care Compare Database	10/1/2021 - 3/31/2022
Noninvasive ventilation	Inpatient LDS SAF	1/1/2017 - 12/31/2021
Patient experience	CMS Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)	4/1/2021 - 3/31/2022
Board certification	American Board of Orthopaedic Surgery (ABOS); National Board of Physicians and Surgeons (NBPS); American Osteopathic Association (AOA)	(a) provided by ABOS and AOA to Doximity prior to 1/26/2023 and (b) self-reported by NBPS-certified orthopedic surgeons to Doximity prior to 1/26/2023

Reperfusion therapy	Inpatient LDS SAF; Outpatient LDS SAF	1/1/2017 - 12/31/2021
Prevention of ER visits after chemotherapy	CMS Care Compare database	1/1/2021 - 12/31/2021
Prevention of unplanned visits after colonoscopy	CMS Care Compare database	1/1/2019 - 12/31/2021
Compliance with septic shock bundle	CMS Care Compare database	4/1/2021 - 3/31/2022
GWTG recognized hospital	American Heart Association Get With The Guidelines (GWTG)	Hospitals must have opted into the public reporting program and been appearing on their public site by 8/31/2022
ACC recognized hospital	American College of Cardiology (ACC)	Hospitals must have opted into the public reporting program by 12/5/2022
STS recognized hospital	Society of Thoracic Surgeons (STS)	Hospitals must have opted into the public reporting program by 12/23/2022
STS/ACC TVT registry recognized hospital	Collaboration between Society of Thoracic Surgeons (STS) and the American College of Cardiology (ACC)	Hospitals must have opted into the public reporting program by 12/30/2022
Structure Measures		

Volume	Inpatient LDS SAF	1/1/2017 - 12/31/2021
	Outpatient LDS SAF	1/1/2020 - 12/31/2021 for hip replacement; 1/1/2018 - 12/31/2021 for knee replacement; 1/1/2017 - 12/31/2021 for prostate cancer surgery and uterine cancer surgery
Nurse Staffing	2021 AHA Annual Survey	1/1/2021 - 12/31/2021
ICU specialists	2021 AHA Annual Survey	1/1/2021 - 12/31/2021
Cardiac intensive care unit	2021 AHA Annual Survey	1/1/2021 - 12/31/2021
NCI cancer center	National Cancer Institute (NCI)	Hospitals must be designated as NCI clinical or comprehensive cancer centers as of 2/2/2023
ACS cancer center	2021 AHA Annual Survey	1/1/2021 - 12/31/2021

CIVIL COVER SHEET

The JS-CAND 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved in its original form by the Judicial Conference of the United States in September 1974, is required for the Clerk of Court to initiate the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

U.S. NEWS & WORLD REPORT, L.P.

(b) County of Residence of First Listed Plaintiff *(EXCEPT IN U.S. PLAINTIFF CASES)*

District of Columbia

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

QUINN EMANUEL URQUHART & SULLIVAN LLP, 50 California St, 22nd Floor, San Francisco, CA 94111, (415) 875-6600

DEFENDANTS

DAVID CHIU, in his Official Capacity as City Attorney of the City and County of San Francisco

County of Residence of First Listed Defendant *(IN U.S. PLAINTIFF CASES ONLY)*

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☒ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☒ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment Of Veteran's Benefits
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury -Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury – Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☒ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities–Employment
- ☐ 446 Amer. w/Disabilities–Other
- ☐ 448 Education

PRISONER PETITIONS

HABEAS CORPUS
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

OTHER
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee–Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC § 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC § 158
- ☐ 423 Withdrawal 28 USC § 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent—Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS–Third Party 26 USC § 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC § 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced & Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation–Transfer ☐ 8 Multidistrict Litigation–Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
28 U.S.C. §§ 2201, 2202; 42 U.S.C. §§ 1983, 1988

Brief description of cause:
Obtain TRO, PI, and other relief to protect U.S. News' rights in the face of unconstitutional intrusions by the government

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, Fed. R. Civ. P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S), IF ANY *(See instructions):*

JUDGE

DOCKET NUMBER

IX. DIVISIONAL ASSIGNMENT (Civil Local Rule 3-2)

(Place an "X" in One Box Only) ☒ **SAN FRANCISCO/OAKLAND** ☐ **SAN JOSE** ☐ **EUREKA-MCKINLEYVILLE**

DATE 01/23/2024

SIGNATURE OF ATTORNEY OF RECORD /s/ John Potter

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS-CAND 44

Authority For Civil Cover Sheet. The JS-CAND 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved in its original form by the Judicial Conference of the United States in September 1974, is required for the Clerk of Court to initiate the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I. a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)."

II. Jurisdiction. The basis of jurisdiction is set forth under Federal Rule of Civil Procedure 8(a), which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.

(1) United States plaintiff. Jurisdiction based on 28 USC §§ 1345 and 1348. Suits by agencies and officers of the United States are included here.

(2) United States defendant. When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.

(3) Federal question. This refers to suits under 28 USC § 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.

(4) Diversity of citizenship. This refers to suits under 28 USC § 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked**.** (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS-CAND 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If the nature of suit cannot be determined, be sure the cause of action, in Section VI below, is sufficient to enable the deputy clerk or the statistical clerk(s) in the Administrative Office to determine the nature of suit. If the cause fits more than one nature of suit, select the most definitive.

V. Origin. Place an "X" in one of the six boxes.

(1) Original Proceedings. Cases originating in the United States district courts.

(2) Removed from State Court. Proceedings initiated in state courts may be removed to the district courts under Title 28 USC § 1441. When the petition for removal is granted, check this box.

(3) Remanded from Appellate Court. Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.

(4) Reinstated or Reopened. Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.

(5) Transferred from Another District. For cases transferred under Title 28 USC § 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.

(6) Multidistrict Litigation Transfer. Check this box when a multidistrict case is transferred into the district under authority of Title 28 USC § 1407. When this box is checked, do not check (5) above.

(8) Multidistrict Litigation Direct File. Check this box when a multidistrict litigation case is filed in the same district as the Master MDL docket.

Please note that there is no Origin Code 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC § 553. Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Federal Rule of Civil Procedure 23.

Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.

Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS-CAND 44 is used to identify related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

IX. Divisional Assignment. If the Nature of Suit is under Property Rights or Prisoner Petitions or the matter is a Securities Class Action, leave this section blank. For all other cases, identify the divisional venue according to Civil Local Rule 3-2: "the county in which a substantial part of the events or omissions which give rise to the claim occurred or in which a substantial part of the property that is the subject of the action is situated."

Date and Attorney Signature. Date and sign the civil cover sheet.