Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Manual

Updated Fall 2024

Table of Contents

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Section 1: PCHQR Program

Overview

Section 1866(k) of the Social Security Act sets forth the requirements for the PCHQR Program and applies to hospitals described in section 1886(d)(1)(B)(v) of the Social Security Act as PPS-exempt Cancer Hospitals (PCHs). The PCHs are excluded from payment under the inpatient prospective payment system (IPPS).

The PCHQR Program is intended to equip consumers with quality-of-care information to make informed decisions about healthcare options. It is also intended to encourage hospitals and clinicians to improve the quality of care provided to patients with cancer by ensuring that providers are aware of, and reporting on, best practices.

Note: This document is intended for use as a reference guide and does not contain specifications for individual measures. Each section provides detailed instructions for successful implementation of the PCHQR Program.

Program Eligibility

The Centers for Medicare & Medicaid Services (CMS) granted the PCH designation to 11 hospitals. A list of hospitals with the PCH designation is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp.html.

IPPS/Long-Term Care Hospital (LTCH) PPS Final Rules

CMS publishes proposed program and policy changes to the PCHQR Program in April. The proposed changes are published to the *Federal Register* and are open to the public for review and comment for 60 days. CMS also provides notices through the QualityNet website to ensure broad awareness. Following the comment period, CMS summarizes the comments and responds to them in the final rule. The final rule is then published in August. In the (fiscal year) FY 2025 IPPS/LTCH PPS final rule, CMS finalized the following:

- Adoption of one new measure, Patient Safety Structural Measure, beginning with the calendar year (CY) 2025 reporting period/FY 2027 program year.
- Modification of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure beginning with CY 2025 reporting period/FY 2027 program year.
- Finalization of a new start date for public display of the Hospital Commitment to Health Equity (HCHE) measure.
- Information for the PCHQR Program is on pages 69455–69488; 69489–69507; and 69577–69580 in the *Federal Register,* Vol. 89, No. 167, published August 28, 2024. The direct download (342 MB) can be accessed at https://www.govinfo.gov/content/pkg/FR-2024-08-07/pdf/2024-16909.pdf.

Previous final rule publications can be found on QualityNet and Quality Reporting Center websites.

Section 2: Measures

The CMS fiscal year spans two calendar years, starting October 1 of the previous year and ending September 30 of the named fiscal year (e.g., FY 2022 started October 1, 2021, and ends September 30, 2022). For the PCHQR Program, a Program Year (PY) is equivalent to a given fiscal year. The PCHQR Program has not included payment incentives since its inception; however, the Program Year structure allows CMS to receive and analyze data of a given Program Year during the following calendar year.

The PCHQR Program has multiple types of measures that are collected and reported, starting with PY 2013 and subsequent years. PCHQR Program measure data are collected by participating PCHs using a variety of data collection methods. Refer to the tables in Section 3 for reporting methods, measure information, and sampling requirements.

Hospitals participating in the PCHQR Program will be required to report the measures listed below. Refer to Appendix A for data submission dates.

The current measure set for the PCHQR Program for PY 2027 is listed below by category:

Safety and Healthcare-Associated Infection (HAI)

- Central Line-Associated Bloodstream Infection Outcome Measure (CLABSI) (Consensus Based Entity [CBE]) # 0139) (PCH-4)
- Catheter-Associated Urinary Tract Infection Outcome Measure (CAUTI) (CBE #0138) (PCH-5)
- Harmonized Procedure Specific SSI Outcome Measure (CBE #0753) (PCH-6 [colon] and PCH-7 [hysterectomy])
- Facility-wide Inpatient Hospital-onset *Clostridioides difficile* Infection (CDI) Outcome Measure (CBE #1717) (PCH-26)
- Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (CBE #1716) (PCH-27)
- Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (CBE #0431) (PCH-28)
- COVID-19 Vaccination Coverage Among HCP (PCH-38)
- Patient Safety Structural measure (PCH-43)

Clinical Process/Oncology Care Measures (OCM)

- Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (CBE #0210) (PCH-32)
- Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (CBE #0215) (PCH-34)

Intermediate Clinical Outcome Measures

- Proportion of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (EOL-ICU) (CBE #0213) (PCH-33)
- Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (CBE #0216) (PCH-35)

Patient Engagement/Experience of Care

- HCAHPS Survey (CBE #0166) (PCH-29)
- Documentation of Goals of Care Discussions Among Cancer Patients (PCH-42)

Claims-Based Outcome Measures

- Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy (PCH-30 and PCH-31)
- 30-Day Unplanned Readmissions for Cancer Patients (CBE #3188) (PCH-36)
- Surgical Treatment Complications for Localized Prostate Cancer (PCH-37)

Health Equity Measures

- Hospital Commitment to Health Equity (PCH-39)
- Screening for Social Drivers of Health (PCH-40)
- Screen Positive Rate for Social Drivers of Health (PCH-41 a-e)[1]

Measure Information

The sections below provide a summary of each measure set and the location of additional measure information.

Healthcare-Associated Infection (HAI)

Beginning with PY 2014, CMS initially adopted two HAI measures, CLABSI and CAUTI, that are stewarded by the CDC. The measure data are reported on a quarterly basis through the NHSN.

Beginning with PY 2015, CMS adopted the SSI measure for the PCHQR Program. This measure assesses the incidence of SSIs following colon surgeries and abdominal hysterectomies performed by PCHs. Users reporting CAUTI, CLABSI, and SSI data must adhere to the definitions and reporting requirements as specified in the NHSN Patient Safety Component Protocol.

Beginning with PY 2018, CMS adopted the following three new measures: NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure, NHSN Facility-wide Inpatient Hospital-onset MRSA Bacteremia Outcome Measure, and NHSN Influenza Vaccination Coverage Among HCP. The CDC published operational guidance documents for PCHs. They are located on the NHSN website under the CMS Requirements. The CDI operational guidance document is available at http://www.cdc.gov/nhsn/pdfs/cms/pchqr/pchqr-cdi-op-guidance.pdf. The MRSA operational guidance document is at http://www.cdc.gov/nhsn/pdfs/cms/pchqr/pchqr-mrsa_op-guidance.pdf.

Beginning with PY 2023, CMS adopted the COVID-19 Vaccination Coverage Among HCP measure for the PCHQR Program. Measure specifications are at https://www.cdc.gov/nhsn/pdfs/CBE/covid-vax-hcpcoverage-rev-2023-508.pdf.

The 2024 NHSN Patient Safety Component Manual is posted on the NHSN website. The surveillance protocols and definitions contained within the 2024 manual should be used for surveillance and data collection beginning on January 1, 2024. Previous versions are available on the NHSN website in the Data Validation section of the website.

***0138:* Catheter-Associated Urinary Tract Infections (CAUTI) (PCH-5)**

The NHSN analysis output option, "Rate Table - CAUTI Data for CMS PPS-Exempt Cancer Hospitals," was created to allow facilities to review those CAUTI data that will be submitted to CMS on their behalf. This report only includes in-plan CAUTI data for each oncology ICU, ward, and step-down unit.

[1] The Screen Positive Rate for Social Drivers of Health measure has five individual Health-related Social Needs: 41a. Screen Positive Rate for Social Drivers of Health - Food Insecurity; 41b. Screen Positive Rate for Social Drivers of Health - Housing Instability; 41c. Screen Positive Rate for Social Drivers of Health - Transportation Needs; 41d. Screen Positive Rate for Social Drivers of Health - Utility Difficulties; 41e. Screen Positive Rate for Social Drivers of Health - Interpersonal Safety

The numerator is defined as the total number of observed healthcare associated CAUTIs among patients in bedded inpatient care locations. The denominator is the total number of indwelling urinary catheter days for each location under surveillance for CAUTI during the data period.

0139: Central Line-Associated Bloodstream Infection (CLABSI) (PCH-4)

The NHSN Analysis Output Option, "Rate Table - CLABSI Data for CMS PPS-Exempt Cancer Hospitals," was created to allow facilities to review those data that will be submitted to CMS on their behalf. This report includes only in-plan CLABSI data for each oncology ICU, ward, and step-down unit.

The numerator is the total number of observed healthcare-associated CLABSI among patients in bedded inpatient care locations. The denominator is the total number of central line days for each location under surveillance for CLABSI during the data period.

0753: Harmonized Procedure Specific Surgical Site Infection (SSI) (PCH-6 [colon] and PCH-7 [hysterectomy])

The SIR of an SSI is calculated by dividing the number of observed infections by the number of expected infections for an operative procedure category. The number of expected infections, in the context of statistical prediction, is derived from a logistic regression model using a baseline time period.

The numerator is the deep incisional primary (DIP) and organ/space SSIs during the 30-day postoperative period among patients at least 18 years of age, who undergo inpatient colon surgeries or abdominal hysterectomies. SSIs will be identified before discharge from the hospital, upon readmission to the same hospital, or during outpatient care or admission to another hospital (post-discharge surveillance). The denominator is the expected number of SSIs obtained using multivariable logistic regression models for colon surgeries and abdominal hysterectomies. These expected numbers are summed by facility and surgical procedure and used as the denominator of this measure.

1717: Facility-wide Inpatient Hospital-onset Clostridioides difficile Infection (CDI) (PCH-26)

PCHs must report CDI laboratory-identified (LabID) events that occur in their EDs, 24-hour observation units, and all inpatient care locations to the CDC's NHSN. The SIR of hospital-onset CDI LabID events will be calculated among all inpatients in the facility.

The numerator is the total number of observed hospital-onset CDI LabID events among all inpatients in the facility. The denominator is the expected number of hospital-onset CDI LabID events, calculated using the facility´s number of inpatient days, bed size, affiliation with medical school, microbiological test used to identify *C. difficile*, and community-onset CDI admission prevalence rate.

NHSN users reporting Facility-wide Inpatient (FacWideIN) CDI LabID event data to the system must adhere to the definitions and reporting requirements for those events as specified in the NHSN Multidrug-Resistant Organism & *Clostridioides difficile* Infection (MDRO/CDI) Module protocol found at http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf. This includes individually mapping all inpatient locations from the entire cancer hospital in NHSN. Facilities must also map and report from EDs (adult and pediatric) and 24-hour observation locations. Facilities will report a single monthly FacWideIN denominator summed for all inpatient locations (total facility patient days and total facility admissions), as well as separate denominators, to capture ED and 24-hour observation location(s) encounters for each mapped location.

1716: Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia (PCH-27)

PCHs must report MRSA blood specimen (bacteremia) LabID events that occur in their EDs, 24-hours observation units, and all inpatient care locations to the CDC's NHSN.

The SIR of hospital-onset unique blood source MRSA LabID events will be calculated among all inpatients in the facility. The numerator is the total number of observed hospital-onset unique blood source MRSA LabID events among all inpatients in the facility. The denominator is the expected number of hospital-onset unique blood source MRSA LabID events, calculated using the facility´s number of inpatient days, bed size, affiliation with medical school, and community-onset MRSA bloodstream infection admission prevalence rate.

NHSN users reporting FacWideIN MRSA bacteremia LabID event data to the system must adhere to the definitions and reporting requirements for those events, as specified in the NHSN MDRO/CDI Module protocol at http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf. This includes individually mapping all inpatient locations from the entire cancer hospital in NHSN. Hospitals must also map and report from EDs (adult and pediatric) and 24-hour observation locations. Facilities will report a single monthly FacWideIN denominator summed for all inpatient locations (total facility patient days and total facility admissions), as well as separate denominators to capture ED and 24-hour observation location(s) encounters for each mapped location.

0431: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (PCH-28)

The Influenza HCP measure assesses the percentage of HCP who receive the influenza vaccination. The measure is designed to ensure that reported HCP influenza vaccination percentages are consistent over time within a single healthcare facility and comparable across facilities.

The denominator includes the number of HCPs working in the healthcare facility for at least one working day between October 1 and March 31 of the subsequent year, regardless of clinical responsibility or patient contact, and is calculated separately for employees, licensed independent practitioners, and adult students/trainees and volunteers. The measure has no exclusions.

The numerator includes the HCP from the denominator population who met the following criteria between October 1 (or when the vaccine became available) and March 31 of the subsequent year and:

- Received an influenza vaccination administered at the healthcare facility, reported in writing (paper or electronic), or provided documentation that influenza vaccination was received elsewhere.
- Had a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine or has a history of Guillain-Barre syndrome within six weeks after a previous influenza vaccination.
- Declined influenza vaccination.
- Had an unknown vaccination status or did not otherwise fall under any of the above-mentioned numerator categories.

3636: COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) (PCH-38)

The COVID-19 HCP measure assesses the percentage of HCP who received an up-to-date COVID-19 vaccination course. Please refer to the following document for up-to-date guidance: https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance508.pdf.

The denominator includes the number of HCP eligible to work in the healthcare facility for at least one day during the reporting period, excluding persons with contraindications to SARS-CoV-2 vaccination.

Denominator exclusions include HCP who were determined to have a medical contraindication or condition specified by the Food and Drug Administration (FDA) labeling or authorization, CDC, or Advisory Committee on Immunization Practices (ACIP) recommendations.

The cumulative number of HCP in the denominator population who are considered up to date with CDC recommended COVID-19 vaccines. Providers should refer to the definition of "up to date" as of the first day of the applicable reporting quarter.

Please refer to https://www.cdc.gov/nhsn/pdfs/nqf/covid-vax-hcpcoverage-rev-2023-508.pdf

N/A: Patient Safety Structural Measure (PCH-43)

The Patient Safety Structural Measure (PSSM) was developed to assess how well hospitals have implemented strategies and practices to strengthen their systems and culture for safety. This measure consists of five sets of complementary statements (or attestations) organized into domains that aim to capture the most salient, systems-oriented actions to advance safety. The five domains are: Domain 1: Leadership Commitment to Eliminating Preventable Harm; Domain 2: Strategic Planning & Organizational Policy; Domain 3: Culture of Safety & Learning Health Systems; Domain 4: Accountability & Transparency; and Domain 5: Patient & Family Engagement.

The PSSM five domains represent separate safety commitments. Each of the five domains include five related attestation statements, and the hospital needs to determine whether they can affirmatively attest to each domain. There is a total of five possible points (one point per domain), and a hospital is not able to receive partial points for a domain.

For more details on the measure specifications and the Attestation Guide, refer to the following QualityNet PCHQR Program Measures page: https://qualitynet.cms.gov/pch/measures/safety

Sampling

There is no sampling for the NHSN measures.

HAI Measures Reporting Period and Submission Deadlines

Hospitals are encouraged to submit their data monthly (within 30 days of the end of the month in which it is collected) to have the greatest impact on infection prevention activities. It is important to review the data that are entered to ensure they are complete and accurate. Data must be reported to NHSN by means of manual data entry into the web-based application or via file imports.

For data to be shared with CMS, each quarter's data must be entered into the NHSN by the CMS data submission deadline, which is approximately four and a half months after the end of the quarter. For example, quarter one data (January 1–March 31) must be entered into NHSN by 23:59 p.m. Pacific Time (PT), on August 15. (If a deadline falls on a weekend or federal holiday, it will be moved to the next business day.) For HAI measure reporting periods and submission deadlines, refer to Appendix A.

Additional Resources

For questions specific to HAI measures, visit the CDC website: http://www.cdc.gov/nhsn/index.html

End-of-Life (EOL) Measures

0210: Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (PCH-32)

Chemotherapy may be used for both the treatment of cancer and for palliation. However, some studies have shown that administering palliative chemotherapy to terminally ill cancer patients may not be beneficial and may be associated with higher rates of interventions.

Those interventions include cardiopulmonary resuscitation in the last week of life, being admitted to an ICU, and dying in a place other than the one they preferred.

The available evidence indicated that receiving chemotherapy, for either treatment or palliation, toward the end of life may be associated with increased hospitalizations, reduced quality of life, and increased costs. The intent of this measure is to evaluate how often chemotherapy is administered near the end of life in PCHs.

This measure is a claims-based process measure, for Medicare fee-for-service (FFS) patients, which evaluates the proportion of patients who died of cancer and received chemotherapy at a PCH in the last 14 days of life. The numerator is defined as patients who received chemotherapy (regardless of intent) in the last 14 days of life. The denominator is defined as all patients who died from cancer. There are no exclusions, risk adjustments, or risk stratifications because the measure is intended to evaluate the quality of life provided to all cancer patients at the end of life. A lower rate is better.

0215: Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (PCH-34)

Research studies have determined that cancer care can become more aggressive towards the end of life. Such aggressive care has been identified to include the underutilization of hospice, which is due to either a lack of referral or late referral to hospice services. In contrast, studies have shown that patients enrolled in hospice are hospitalized less frequently, receive fewer procedures, and may demonstrate significant cost savings if enrolled in a timely manner. A factor leading to this aggressive treatment may be that end-of-life discussions are not being held with patients and their families. It is not expected that PCHs will achieve perfect rates with this measure, as there may be mitigating reasons that preclude enrollment in hospice. The intent of this measure is to evaluate whether patients were admitted to hospice. This measure is linked to another program measure, CBE #0216 (below).

This is a claims-based process measure which includes all Medicare FFS patients at the PCH. The denominator for this measure is defined as all Medicare FFS patients of the PCH who died of cancer in the defined timeframe. The numerator is those patients included in the denominator who were not enrolled in hospice. The measure specifications include no denominator exclusions nor any risk adjustment or risk stratification. A lower rate is better.

0213: Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (PCH-33)

As discussed with measure CBE #0210, numerous research studies have determined that cancer care can become more aggressive towards the end of life, which can lead to a lower quality of care and quality of life. Aggressive care may include admission to an ICU. Studies have shown that these ICU admissions may lead to more interventions, may be potentially ineffective, and may exact a toll on patients, families, and caregivers. ICU admissions at the end of life are also costly.

As with the other end-of-life metrics included in the program, this measure seeks to evaluate end-of-life care at PCHs. CBE #0213 is a claims-based intermediate clinical outcome measure that uses Medicare FFS billing data.

The measure denominator is defined as the Medicare FFS patients in the PCH who died of cancer. The numerator consists of those patients in the denominator who were admitted to the ICU in the last 30 days of life. As with the other end-of-life measures, there are no exclusions, nor is there a provision for risk adjustment or risk stratification. A lower rate is better.

0216: Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (PCH-35)

The potential impact of hospice care on quality of life and cost is outlined in the discussion of CBE #0215. While over time there has been an increasing trend to admit cancer patients to hospice, the number of patients admitted close to death was also seen to be increasing.

With cancer patients being identified as the largest users of hospice, it is also noted that they are the cohort with the highest rates of hospice stays of less than three days. Research shows the importance of an early admission to hospice and indicates that, when hospice was initiated earlier than three days prior to death, patients' families were more likely to indicate that end-of-life care was excellent. The researchers noted that enhancing counseling of patients and families and early referral to palliative care services could result in more preference-sensitive care for patients and overall improvement in the quality of care for cancer patients at the end of life.

This measure, closely related to CBE #0215, seeks to incentivize timely discussions and admissions to hospice within the PCH setting, which in turn may lead to improved quality of care. This is a claims-based intermediate clinical outcome measure for Medicare patients within PCHs. The denominator consists of those Medicare FFS patients who died from cancer and were admitted to hospice. The numerator is the number of patients from the denominator who spent three or less days in hospice. There are no exclusions from the denominator, nor risk adjustment or risk stratification, as the goal of the measure is to assess the quality of care provided to all cancer patients at the end of life. A lower rate is better.

EOL Measures Reporting and Submission

The end-of-life clinical process and intermediate clinical outcome measures are claims-based measures, and no additional data submission is required by PCHs, and there is no sampling provision. The CMS analytics contractor will calculate these performance rates based upon Medicare administrative claims data and provide confidential feedback reports to PCHs.

Additional Resources

Please refer to the following resources:

- CMS Measures Inventory Tool: https://cmit.cms.gov/cmit/#/MeasureInventory
- Additional EOL measure information and resources can also be found on QualityNet: https://qualitynet.cms.gov/pch/measures/end-of-life

Patient Engagement/Experience of Care

The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The HCAHPS Survey is a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS Survey items complement the data that hospitals currently collect to support improvements in internal customer services and quality related activities. For detailed information, refer to www.hcahpsonline.org.

0166: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (PCH-29)

The updated HCAHPS Survey produces 11 reported measures. Multi-item measures include: 1) communication with doctors; 2) communication with nurses; 3) restfulness of hospital environment; 4) care coordination; 5) responsiveness of hospital staff; 6) communication about medicines; 7) discharge information.

Single-item measures include: 1) cleanliness; 2) information about symptoms; 3) overall rating of the hospital; and 4) recommend the hospital.

The updated HCAHPS Survey has a total of 32 questions. Eight questions were added, and five questions were removed. The updated survey is to be administered beginning with patients discharges as of January 1, 2025, and forward.

Sampling

The HCAHPS specifications describe a precise method for sampling, with patients surveyed throughout each month of the year. PCHs must target at least 300 completed surveys over four calendar quarters in order to attain the reliability criterion CMS has set for publicly reported HCAHPS scores.

Additionally, for PCHs that obtain fewer than 100 completed surveys, an appropriate footnote will be applied on the data catalog on Data.cms.gov. The footnote will alert individuals to review the data cautiously as the number of surveys may be too low to reliably access a PCH's performance.

HCAHPS Measure Reporting Period and Submission Deadlines

For the HCAHPS measure reporting period and submission deadlines, refer to Appendix A.

Additional Resources

For detailed information, refer to the HCAHPS specifications.

Documentation of Goals of Care Discussions Among Cancer Patients (PCH-42)

Goals of care discussion are intended to inform future treatment decisions that account for and are responsive to the interests expressed by patients with advanced cancer and can also impact referrals to palliative care and end-of-life treatments. Goals of care discussions are discussions between the patient and the oncology team, and the primary oncologist is responsible for ensuring documentation of these discussions.

The Documentation of Goals of Care Discussions Among Cancer Patients measure is a process measure which focuses on the essential process of documenting goals of care conversations in the electronic health record (EHR) by assessing the presence of this documentation in the medical record. The intent of this measure is for PCHs to track and improve this documentation in a manner that is retrievable by all members of the PCH healthcare team, and to facilitate the delivery of care that aligns with patients' and families' values and unique priorities. This measure assesses goals of care discussion documentation among patients with cancer who die while receiving care at the reporting PCH.

This measure requires the use of both hospital administrative data (non-claims), for example attestation in charting system, for clinical information and discrete documentation in the EHR documenting the goals of care discussion.

The population is the number of patients who died in the measurement period, including patients participating in clinical trials, as long as these patients meet the criteria for the measure's population. This population is defined using PCH administrative data (non-claims) and discrete documentation in the EHR as follows:

- Patients who died at the PCH in the measurement period; and
- Who had a diagnosis of cancer; and
- Who had at least two eligible contacts at a PCH within the six months prior to their date of death.

Eligible contacts are inpatient admissions and hematology or oncology ambulatory visits at the reporting hospital.

The denominator is number of patients meeting the criteria for inclusion in the measure's population in the reporting period.

The numerator is the number of patients who were included in the denominator of whom a Goals of Care conversation was documented in a structured field in the medical record. The measure will require any documentation in one or more patient goals fields. To meet the requirements for inclusion in the numerator, the documentation in the EHR will be required to include either of the following:

- Any documentation in one or more patient goals fields in the electronic medical record, or
- Documentation that the patient opted not to have a goal of care discussion. Documentation may originate from any visit type or provider as permitted by the PCH.

Any member of the PCH healthcare team could perform such documentation for purposes of the measure, but we strongly encourage a patient's oncologist to ensure appropriate discussions of goals of care occur and to oversee the documentation of the goals of care discussion.

Documentation of Goals of Care Discussions Among Cancer Patients measure resources can be found on QualityNet: https://qualitynet.cms.gov/pch/measures/goals

Claims-Based Outcome Measures

3490: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (PCH-30 and PCH-31)

Admission and ED Visits for Patients Receiving Outpatient Chemotherapy (referred to as the outpatient chemotherapy measure) estimates hospital-level, risk-adjusted rates of inpatient admissions or ED visits for cancer patients greater than or equal to 18 years of age for at least one of the following diagnoses: anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis (within 30 days of hospital-based outpatient chemotherapy treatment). Rates of admission and ED visits are calculated and reported separately.

Additional background information about the measure can be found in the Measure Technical Report and Data Dictionary (Appendix A of the Measure Technical Report), located at the following link: https://qualitynet.cms.gov/pch/measures/chemotherapy/methodology

Chemotherapy treatment can have severe, predictable side effects, which, if inappropriately managed, can reduce patients' quality of life and increase healthcare utilization and costs.

This measure aims to assess the care provided to cancer patients and encourage quality improvement efforts to reduce the number of potentially avoidable inpatient admissions and ED visits among cancer patients receiving chemotherapy in a hospital outpatient setting. Improved management of these potentially preventable clinical conditions that are frequent side effects of chemotherapy treatment (e.g., anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis) could reduce admissions and ED visits and increase patients' quality of care and quality of life. This measure encourages hospitals to use American Society of Clinical Oncology, National Comprehensive Cancer Network, Oncology Nursing Society, Infectious Diseases Society of America, and other professional society guidelines to integrate and promote use of evidence-based interventions to prevent and treat common side effects and complications of chemotherapy.

The measure denominator includes Medicare FFS patients, aged 18 years and older at the start of the performance period, with a diagnosis of any cancer (except leukemia), who received at least one outpatient chemotherapy treatment at the reporting hospital during the performance period.
The measure does not include procedure codes for oral chemotherapy, so patients receiving oral chemotherapy are not captured in the cohort. The measure excludes the following from the cohort:

- Patients with a diagnosis of leukemia at any time during the performance period
- Patients who were not enrolled in Medicare FFS Parts A and B in the year prior to the first outpatient chemotherapy treatment during the performance period
- Patients who do not have at least one outpatient chemotherapy treatment followed by continuous enrollment in Medicare FFS Parts A and B in the 30 days after the procedure

The Measure Technical Report (referenced above) contains rationale and complete coding for exclusions.

The numerator for this measure is a risk-adjusted outcome measure and does not have a traditional numerator like a process measure. We use this field to define the measured outcomes of interest, given that this measure reports the hospital rates of two outcomes separately: admission and ED visits.
The outcomes for this measure are one or more inpatient admissions, and one or more ED visits without an admission, for one of the following diagnoses: anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis (within 30 days of receiving hospital-based outpatient chemotherapy treatment for cancer).
The qualifying diagnosis on the admission or ED visit claim must be either the principal diagnosis or a secondary diagnosis accompanied by a principal diagnosis of cancer. Chemotherapy measure resources can be found on QualityNet: https://qualitynet.cms.gov/pch/measures/chemotherapy

3188: 30-Day Unplanned Readmissions for Cancer Patients (PCH-36)

The 30-Day Unplanned Readmissions for Cancer Patients measure is a cancer-specific measure. It provides the rate at which all adult cancer patients covered as FFS Medicare beneficiaries have an unplanned readmission within 30 days of discharge from an acute care hospital. The unplanned readmission is defined as a subsequent inpatient admission to a short-term acute care hospital, which occurs within 30 days of the discharge date of an eligible index admission and has an admission type of "emergency" or "urgent."

This outcome measure demonstrates the rate at which adult cancer patients have unplanned readmissions within 30 days of discharge from an eligible index admission. The numerator includes all eligible unplanned readmissions to any short-term acute care hospital – defined as admission to the PPS-Exempt Cancer Hospital (PCH), a short-term acute care PPS hospital, or Critical Access Hospital (CAH) – within 30 days of the discharge date from an index admission that is included in the measure denominator.

Readmissions with an admission type (UB-04 Uniform Bill Locator 14) or "emergency = 1" or "urgent = 2" are considered unplanned readmissions within this measure.

Readmissions for patients with progression of disease (using principal diagnosis of metastatic disease as proxy) and for patients with planned admissions for treatment (defined as a principal diagnosis of chemotherapy or radiation therapy) are excluded from the measure numerator.

The denominator includes inpatient admission for all adult FFS Medicare beneficiaries where the patient is discharged from a short-term acute care hospital (PCH, short-term care PPS hospital, or CAH) with a principal or secondary diagnosis (i.e., not admitting diagnosis) of malignant cancer within the defined measurement period. The measure excludes the following index admissions from the measure denominator:

1. Less than 18 years of age;
2. Patients who died during the index admission;
3. Patients discharged AMA;
4. Patients transferred to another acute care hospital during the index admission;
5. Patients discharged with a planned readmission;
6. Patients having missing or incomplete data; and
7. Patients not admitted to an inpatient bed.

Cancer readmission measure resources can be found on QualityNet:
https://qualitynet.cms.gov/pch/measures/readmissions

N/A: Surgical Treatment Complications for Localized Prostate Cancer (PCH-37)

The Surgical Treatment Complications for Localized Prostate Cancer measure addresses complications of a prostatectomy. The outcomes selected for this measure are urinary incontinence (UI) and erectile dysfunction. Specifically, the measure uses claims to identify UI and erectile dysfunction among patients undergoing localized prostate cancer surgery and uses this information to derive hospital-specific rates. This measure will be calculated using Medicare FFS claims, resulting in no new data reporting for the PCHs.

This outcome measure analyzes hospital/facility-level variation in patient-relevant outcomes during the year after prostate-directed surgery. The outcomes are rescaled to a 0-100 scale, with 0=worst and 100=best. The numerator includes patients with diagnosis claims that could indicate adverse outcomes following prostate-directed surgery. The numerator is determined by:

1. Calculating the difference in a number of days with claims for UI or ED the year after versus the year before prostate surgery for each patient.
2. Truncating (by Winsorizing) to reduce the impact of outliers.
3. Rescaling the difference from 0 (worst) to 100 (best).
4. Calculating the mean score of each hospital based on all of the different values for all of the patients treated at that hospital.

The denominator is determined by the following:

1. Men aged 66 or older at the time prostate cancer diagnosis with at least two ICD diagnosis codes for prostate cancer separated by at least 30 days.
2. Men who survived at least one year after prostate-directed therapy.
3. Codes for prostate cancer surgery (either open or minimally invasive/robotic prostatectomy) at any time after the first prostate cancer diagnosis.
4. Continuous enrollment in Medicare Parts A and B (and no Medicare Part C [Medicare Advantage]) enrollment) from one year before through one year after prostate-directed therapy.

This measure excludes patients with metastatic disease, patients with more than one nonhematologic malignancy, patients receiving chemotherapy, patients receiving radiation, and/or patients who die within one year after prostatectomy.

Prostate Cancer measure resources can be found on QualityNet:
https://qualitynet.cms.gov/pch/measures/prostate

Health Equity Measures

HCHE (PCH-39)

The HCHE measure accesses PCH commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for populations that have been disadvantaged, marginalized, and underserved by the healthcare system. This includes but is not limited to racial and ethnic minority groups, LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorities, and people facing socioeconomic challenges.

The HCHE measure consists of five attestation-based questions, each representing a separate domain of commitment. Each of the domains is represented in the denominator as one point, for a total of 5 points (one per domain).

The numerator captures the total number of domain attestations to which the PCH is able to affirm. PCHs receive only one point for each domain if they attest "yes" to all related elements. For example, a PCH that affirmatively attests "yes" to each element of the five domains will receive the maximum five points.

HCHE measure specifications and resources can be found on QualityNet here:
https://qualitynet.cms.gov/pch/measures/hche

Screening for Social Drivers of Health (SDOH-1) (PCH-40)

Health-related social needs (HSRNs) are defined as individual-level, adverse social drivers that negatively impact a person's health or healthcare, which are significant risk factors associated with health outcomes along with increased healthcare utilization.

The following five core domains were selected to screen for HSRNs in the SDOH-1 measure:
1) food insecurity; 2) housing instability; 3) transportation needs; 4) utility difficulties; and
5) interpersonal safety.

The SDOH-1 measure assesses the total number of patients, aged 18 years and older, screened for all five of the following HRSNs - food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

The denominator is the number of patients who were admitted to a PCH and who were 18 years or older on the date of admission. The following denominator exclusions apply: 1) patients who opt-out of screening; and 2) patients who are themselves unable to complete the screening during their PCH stay and have no legal guardian/caregiver able do so on the patient's behalf during their PCH stay.

SDOH-1 measure specifications and resources can be found on QualityNet:
https://qualitynet.cms.gov/pch/measures/screening

Screen Positive Rate for Social Drivers of Health (SDOH-2) (PCH-41 a-e)

While the SDOH-1 measure enables identification of individuals with HSRNs, the Screen Positive Rate for Social Drivers of Health measure would allow providers to capture the magnitude of these needs and even estimate the impact of individual-level HSRNs on healthcare utilization when evaluating quality of care. Reporting of screen positive rates for each HRSN domain could inform actionable planning by PCHs towards closing equity gaps unique to the populations they serve and enable the development of individual patient action plans. The SDOH-2 measure assesses the percent of patients admitted to the PCH who are 18 years or older at time of admission who were screened for all five HRSNs and who screened positive for one or more of the five HRSNs - food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety (reported as five separate rates).

The numerator consists of the number of patients admitted to a PCH who were 18 years or older on the date of admission, who were screened for all five HRSNs, and who screened positive for having a need in one or more of the five HRSNs (calculated separately).

The denominator consists of the number of patients admitted to a PCH who are 18 years or older on the date of admission and are screened for all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety) during their PCH stay. Denominator exclusions include:

1) Patients who opt-out of screening; and
2) Patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

SDOH-2 measure specifications and resources can be found on QualityNet: https://qualitynet.cms.gov/pch/measures/screening

Section 3: Data Reporting

To meet program requirements, PCHs are required to submit specific quality measures to CMS, beginning with the FY 2013 payment determination year. Participating facilities must comply with the program requirements, including public reporting of the measure rates in the Provider Data Catalog at Data.cms.gov (https://data.cms.gov/).

Data for the PCHQR Program measures are collected by participating PCHs using a variety of methods. PCHs participating in the PCHQR Program must submit the required data via the acceptable methods of transmission no later than 11:59 p.m. PT on the submission deadline date as established by CMS. Only data submitted according to the established deadlines of CMS qualify for inclusion in the PCHQR Program.

Appendix A provides specific data submission deadlines for the required PCHQR Program measures by data collection period due date. The reference periods noted for CLABSI, CAUTI, SSI, CDI, and MRSA refer to event dates.

The document displaying the program requirements by fiscal year, PCHQR Program Measure Crosswalk, is located on the PCHQR Program Resources tab of QualityNet.

Reporting Methods

The PCHQR Program measures are collected by participating PCHs using a variety of data collection methods. The table below provides an overview of the measure types and reporting methods.

Measure Topic/Names	Method of Reporting
Safety/HAI • CLABSI • CAUTI • Harmonized Procedure Specific SSI • CDI • MRSA • HCP Influenza Vaccination • HCP COVID-19 • PSSM	Via the CDC NHSN
EOL Measures • Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life • Proportion of Patients Who Died from Cancer Not Admitted to Hospice • Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days • Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life	Collected by CMS through claims data (No action required by facilities to collect and submit data.)
Patient Engagement/Experience of Care • HCAHPS	Submitted via vendor or uploaded via the Hospital Quality Reporting system using the online data entry tool or in XML format.
• Documentation of Goals of Care Discussions Among Cancer Patients	Submitted via the HQR System using the online data entry tool

Measure Topic/Names	Method of Reporting
Claims-Based Outcome Measures • Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy • 30-Day Unplanned Readmissions for Cancer Patients • Surgical Treatment Complications for Localized Prostate Cancer	Calculated by CMS through claims data (No action required by facilities to collect and submit any additional data.)
Health Equity Measures • Hospital Commitment to Health Equity • Screening for Social Drivers of Health • Screen Positive Rate for Social Drivers of Health	Submitted via the HQR System using the online data entry tool.

Specific instructions for submitting measures using the HQR Simple Data Entry Tool can be found on the PCHQR Program Events On Demand page of QualityReportCenter.com.

Extraordinary Circumstances

A facility can request an exception from various quality reporting program requirements due to extraordinary circumstances that are beyond the control of the facility. To request an exception, complete and submit the Extraordinary Circumstances Exceptions (ECE) Request Form located on the QualityNet PCHQR Program Resources tab (under Forms) within 90 days of the disaster or extraordinary circumstance.

Measure Exception Form

For the CDC NHSN measures, some hospitals may not have locations that meet the NHSN criteria for CLABSI or CAUTI reporting. Other hospitals may perform so few procedures requiring surveillance under the SSI measure that the data may not be sufficiently reliable for quality reporting purposes in a Program Year. Reporting will not be required for the NHSN SSI measures if the PCH performed a combined total of nine or fewer colon and abdominal hysterectomy procedures in the calendar year prior to the reporting year. To indicate that the NHSN SSI data are not being reported, the Measure Exception Form should be completed using the top portion of the form.

The Measure Exception Form is located on QualityNet on the PCHQR Program Resources page.

Section 4: Hospital Quality Reporting (HQR) System Registration Process

To participate and submit data for reporting in the PCHQR Program, facilities must register for access to the HQR System. More information regarding this process can be found on the HQR Registration page.

All users requesting access to the HQR System must complete identify proofing to verify their identity. This mandatory registration process is used to maintain the confidentiality and security of healthcare information and data transmitted via the HQR System. The Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) system is a secure identity management portal for users of the HQR System, and it streamlines the login process by allowing access to all CMS Quality Systems with one login.

PCHQR Program Requirements

The PCHQR Program requirements are listed below. Click on the hyperlink imbedded within the text for detailed instructions for each step, as necessary.

1. Register for a HARP Account.
2. Maintain an active Security Official (SO).
3. Have a Notice of Participation (NOP).
4. Submit data based on the data collection and submission timelines.
5. Complete the Data Accuracy and Completeness Acknowledgement (DACA) by the submission deadline.

Hospital Quality Reporting (HQR) System Access – Getting Started with HARP

Creating an account via HARP provides uses with User ID a password that can be used to sign into multiple CMS applications. It also provides a single location for users to modify their user profile, change their password, update their challenge question, and add and remove two-factor authentication devices.

Before logging in to the HQR System for the first time, a user must establish a HARP Account. Please refer to the HARP for HQR User Guide for detailed instructions.

Please refer to the following resources for additional guidance:

- HARP Frequently Asked Questions (FAQ)
- HARP Registration Training Video
- HARP Manual Proofing Training Video

QualityNet Security Official (SO)

The PCHQR Program strongly recommends every facility have at least one QualityNet SO. As a best practice, it is also recommended that facilities designate a minimum of two QualityNet SOs, one to serve as the primary *QualityNet* SO and the other to serve as the alternate SO. To keep your facility's account active, your SO should sign into the HQR System at least every 60 days and change the password at least every 60 days. More frequent access and updating are encouraged to keep your account active. If it becomes necessary to reactivate your account, call the QualityNet Service Center at (866) 288-8912.

Security Official Responsibilities

The PCH SO has the following responsibilities:

- Creating, approving, editing, and terminating HARP accounts for their PCH
- Assigning user roles for basic users within their PCH to ensure users' access to the secure web-based applications
- Monitoring the PCH's HQR System usage to ensure security and confidentiality is maintained
- Serving as a point of contact for information regarding the HQR system.

Non-Administrative/Basic User

Any user not designated as a QualityNet SO or a QualityNet Security Designate is considered a non-administrative user, or Basic User. Various roles to fit job needs can be assigned to the non-administrative user. If assigned the appropriate roles, the user may perform one or more of the following tasks:

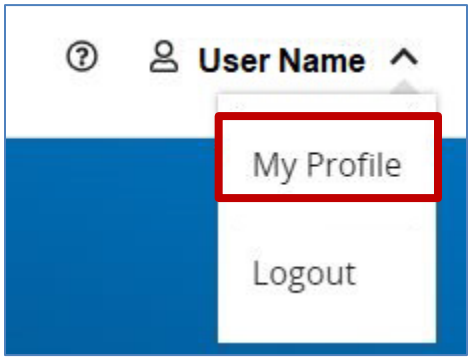
- Access reports
- Authorize vendors to submit data
- Manage measures
- Manage Notice of Participation
- Manage security
- View/edit online forms

Requesting the Security Official (SO) Role in HARP

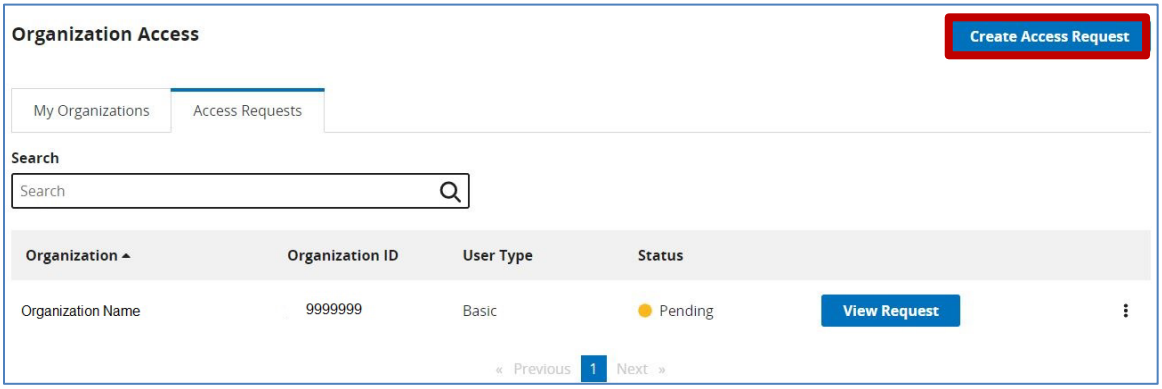
Each organization needs to designate a SO responsible for approving individuals for access to various programs within their organization.

New users (those with no current affiliation to any organization) to HQR: You must contact your SO to request access. If there is no current SO at their organization, you will need to contact the Center for Clinical Standards and Quality (CCSQ) Service Center at qnetsupport@cms.hhs.gov or (866) 288-8912 for all access requests.

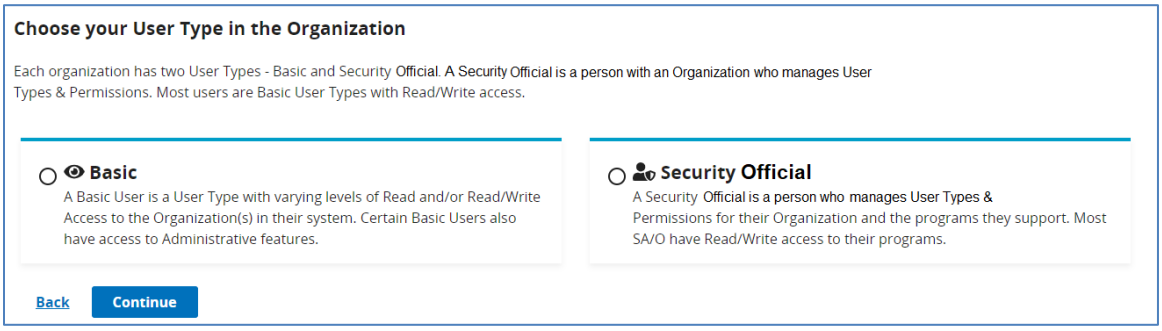
1. Log into HQR (http://hqr.cms.gov). From the home page, under your **User Name,** select **My Profile** from the drop-down in the upper-right hand corner.



2. From this page, you can request access or view access. Select **Create Access Request.**



3. Select either **Basic User** or **Security Official** when prompted to **Choose Your User Type in the Organization**.



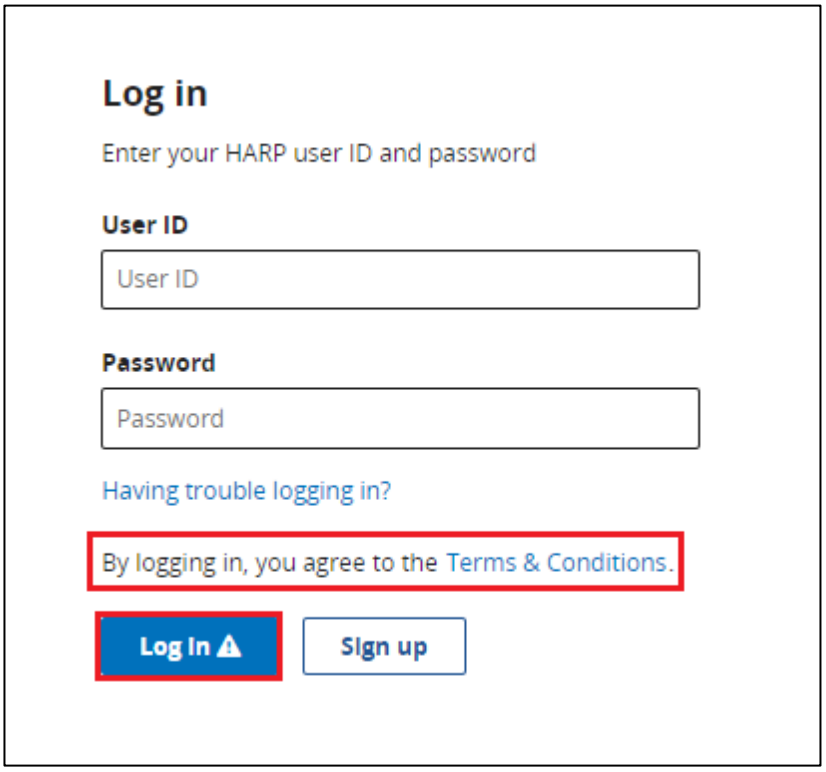
4. Select your required permissions, **Review** then, and click **Continue** when ready.
5. You will be notified via email when your role request has been approved or rejected. For additional information on the HARP Process, please visit the Getting Started with Quality Net page at https://qualitynet.cms.gov/getting-started#tab1.

Logging In to the Hospital Quality Reporting (HQR) System

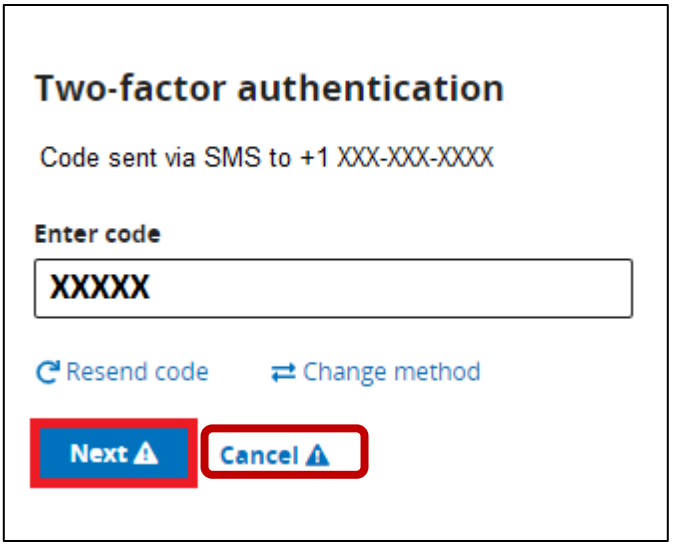
After establishing your HARP credentials, a user will have access to the HQR System.

To access the HQR System:

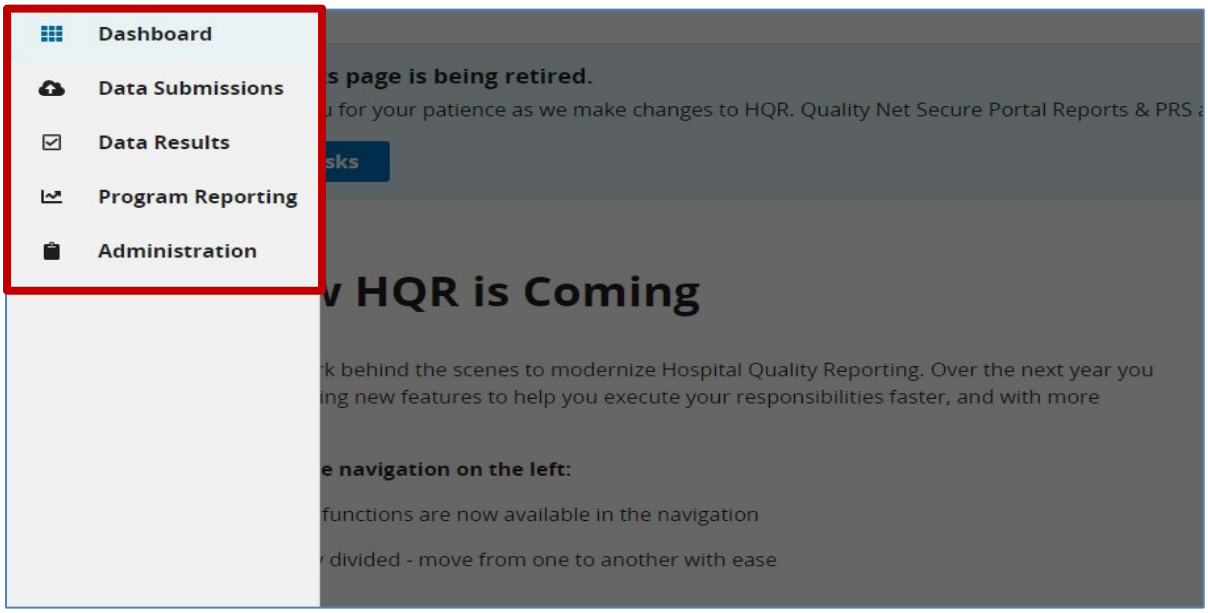
1. Go to the HQR Sign In page and enter your HARP **User ID** and **Password**, then select **Login**. By logging in, you agree to the Terms & Conditions. Then, select **Login**.



2. You will be directed to the **Two-Factor Authentication** page. Select the device you would like to verify your account via **Text** or **Email**. Enter the six-digit code sent to your device. Select **Next**.



3. The Hospital Quality Reporting home page appears, and you can make selections from the navigation pane on the left-hand side



The user may perform one or more of the following tasks:

- Access reports
- Manage measures
- Manage Notice of Participation
- Manage security
- View/edit online forms

User Permissions

For the PCHQR Program, there are only two types of user designations for any of the authorized permissions listed below: **Update** and **Read Only**. The **Update** designation permits a user to edit information within the application; the **Read Only** designation just permits the user to browse information. Below is a list of permissions that may be assigned to a user participating in the PCHQR Program.

Notice of Participation

- PCHQR Notice of Participation Read
- PCHQR Notice of Participation Update

Web-Based Measure/DACA Application

- PCHQR Web-Based MSR DACA Read
- PCHQR Web-Based MSR DACA Update

Reports

- PCHQR Reports Read
- PCHQR Reports Update
- PCHQR Feedback Reports
- PCHQR Preview Reports
- HCAHPS Warehouse Feedback Reports (accessed under IQR)

Vendor Management

- PCH Vendor Management

File Exchange

- File Search and Exchange

Manage Security Settings

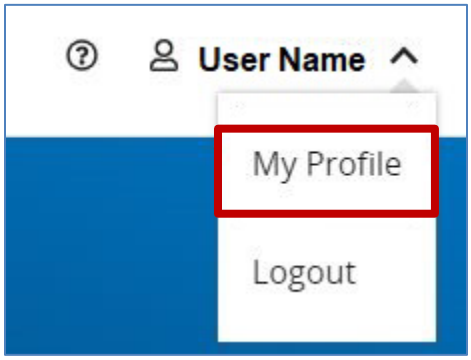
After gaining access to the HQR System, users can manage their account information on the home page. Refer to the instructions below to update/change the settings for the following topics:

- Update account information
- Reset or change passwords
- Update security questions
- Update two-factor devices

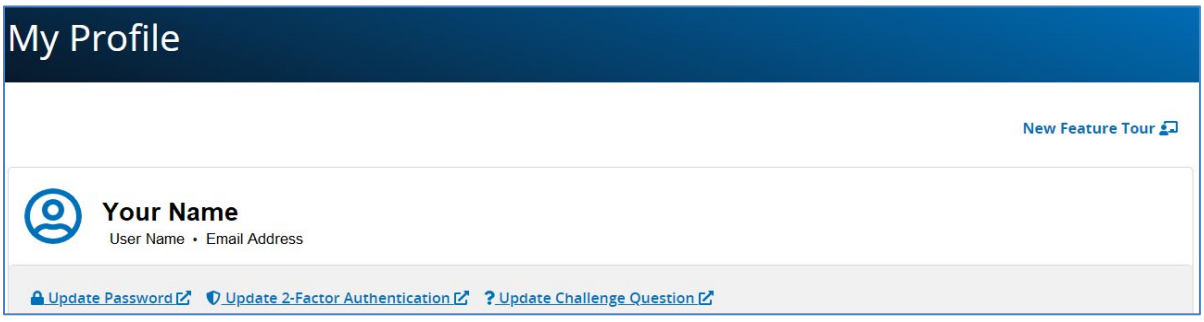
Update Account Information

To update your account information:

1. From the HQR Home page select **My Profile** from the drop-down under your **User Name** in the upper right hand corner.

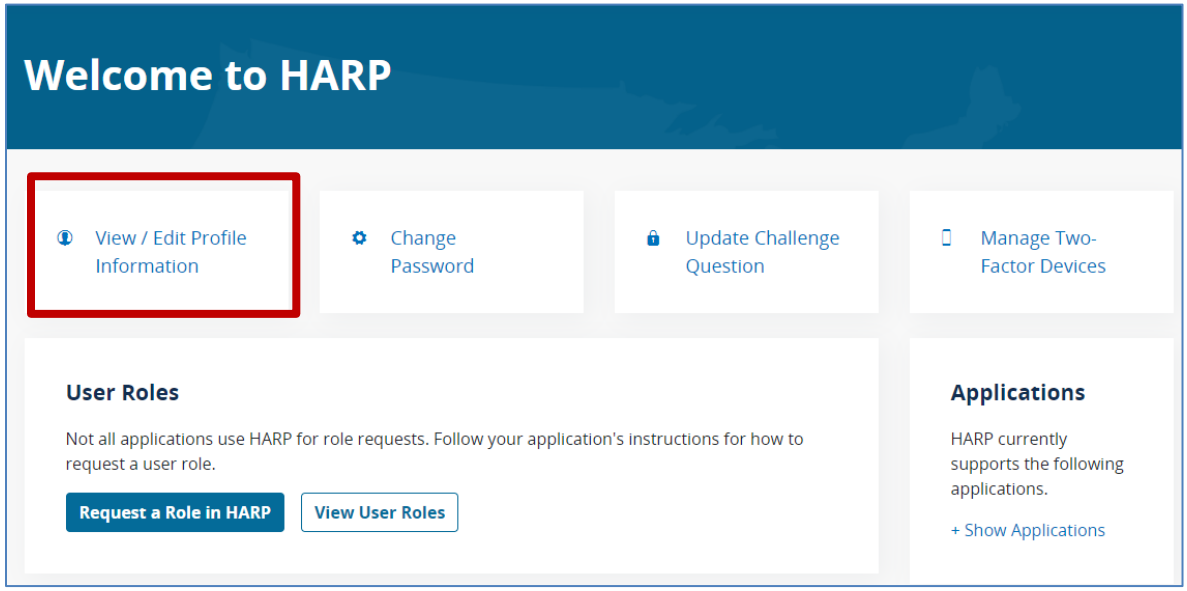


2. The **My Profile** page will open. At the top of the page, you have options to **Update Password**, **Update 2-Factor Authentication**, and **Update Challenge Question**

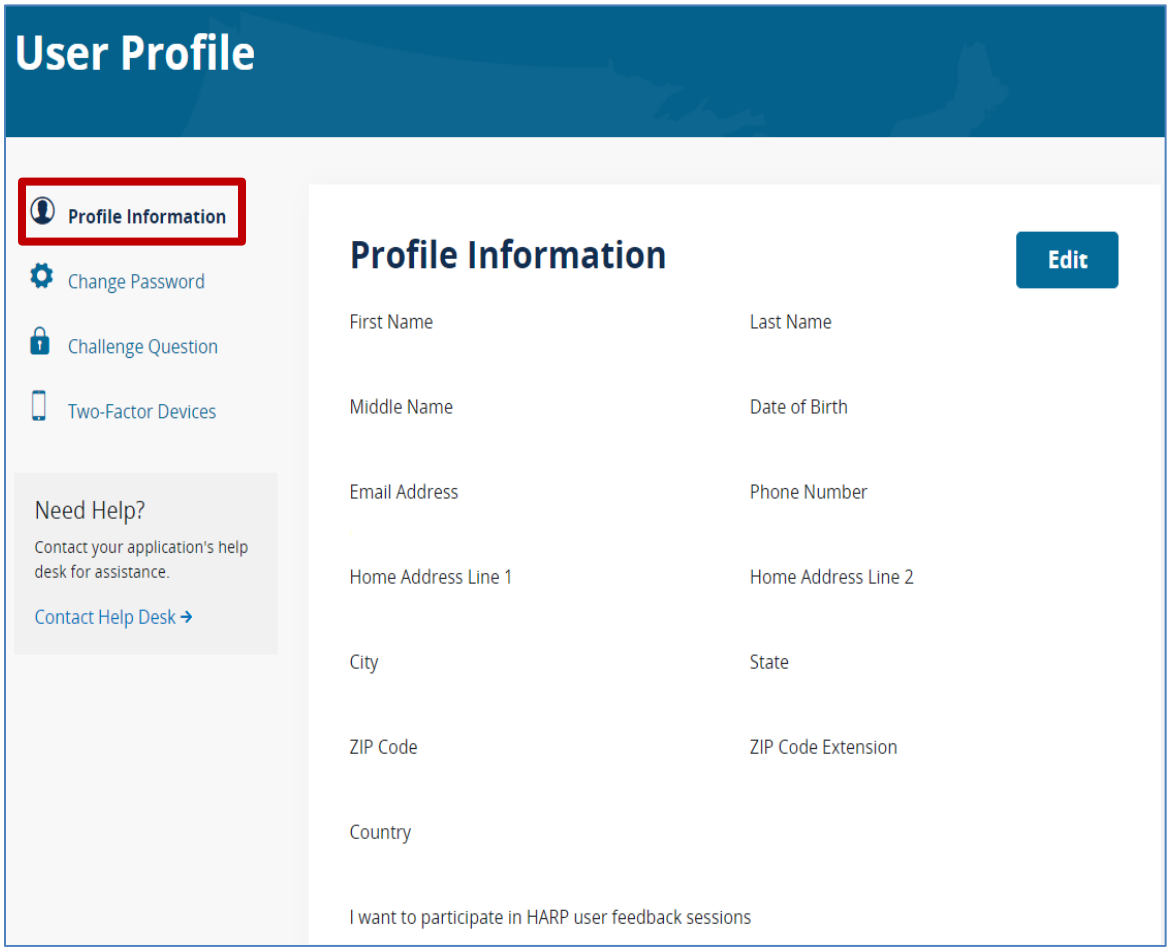


Update Profile Information

1. To update your profile, on the HARP (harp.cms.gov) User Profile page, select **View/Edit Profile Information.**



2. Select **Profile Information**.

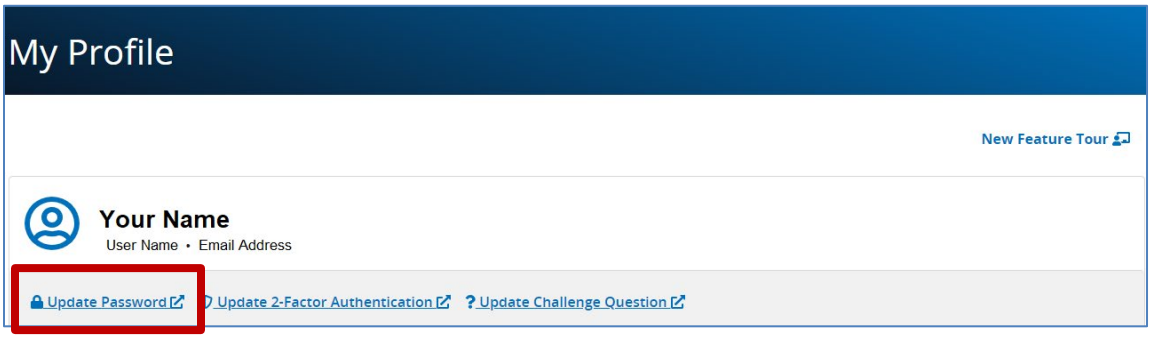


3. The Profile Information screen will appear, and the fields will be populated with your information. You can select the **Edit** and change the desired field(s). Then, select **Save** to record your changes.

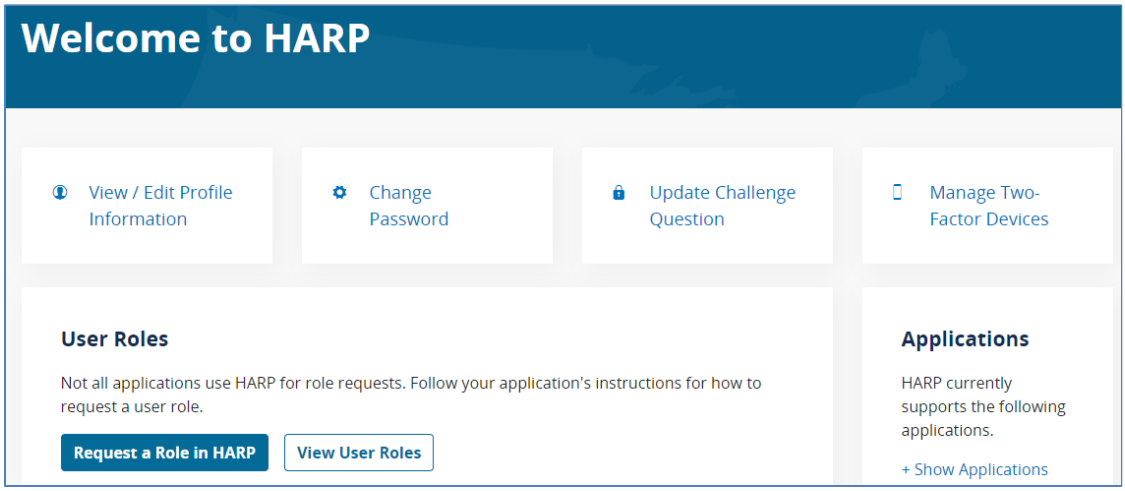
Password Reset/Change

The QualityNet HQR System requires a password reset/change **every 60 days**. To change your password, complete the following steps:

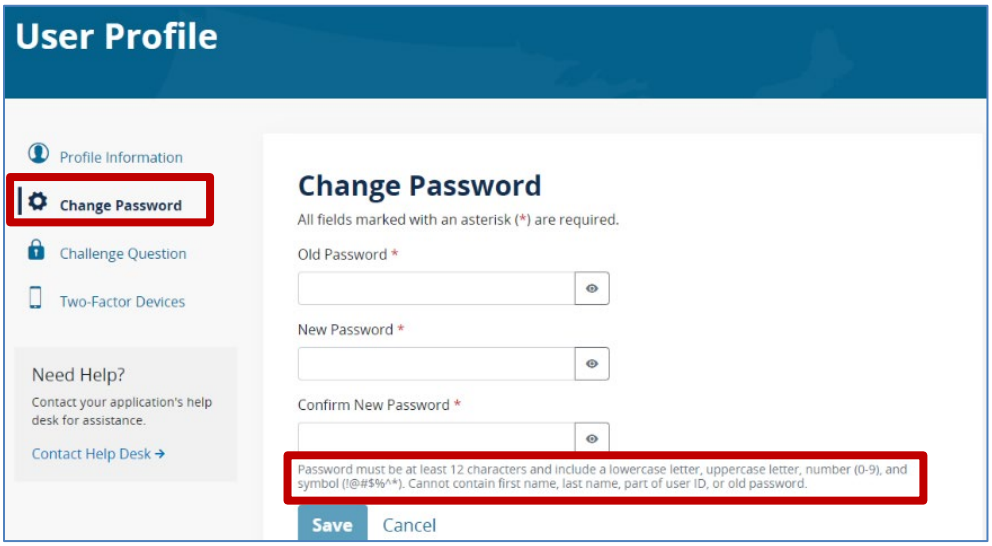
1. On the My Profile page, select **Update Password**.



2. You will be directed to the HARP site (harp.cms.gov). You will then need to log in with your HARP credentials to proceed. Once logged in, select **Change Password**.



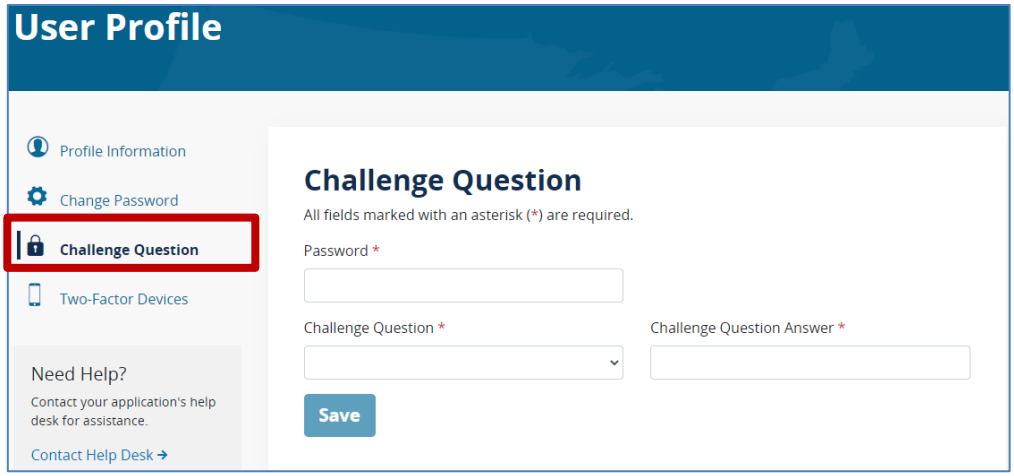
3. The Change Password screen will open. Complete all fields and then select the **Save** button to change the password. Review password rules before changing your password. Rules are located on the Change Password page as shown below.



Update Challenge Questions

To update your security questions:

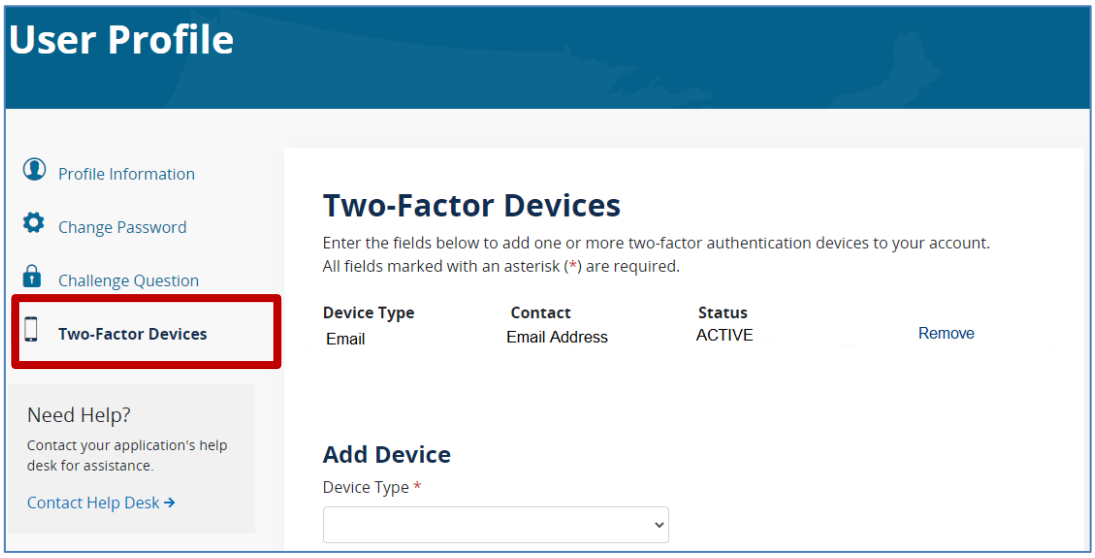
1. On the HARP (harp.cms.gov) User Profile page, select **Challenge Question**.



2. The Challenge Question screen will open. Complete all fields and then select the **Save** button to update your challenge question.

Update Two-Factor Devices

1. On the HARP (harp.cms.gov) *User Profile* page, select **Two-Factor Devices**.



2. The Two-Factor Devices screen will open. Follow the prompts to **Add Device** and then select the **Submit** button to update your device list. You can also remove devices from our account by selecting **Remove** by the appropriate device.

Section 5: Vendor Management

The HQR System's Vendor Management process allows users to assign permissions and manage vendors for all applicable hospitals from one page. The Vendor Management allows for the following capabilities:

- Assign, modify, and remove vendor access for data submissions all from one page.
- Receive instant confirmation that vendors are added, suspended, or removed.
- Resume access for vendors previously associated with your organization with one click of a button.

Facilities may elect to use a vendor to collect and submit data on their behalf. A vendor must have an assigned vendor ID and be authorized to submit data prior to PCH authorization to submit data or have access to its facility's data and/or reports. Vendor authorization for participants in the PCHQR Program is limited to HCAHPS data only at this time.

Note: The PCH may authorize a vendor to submit data on behalf of the facility. However, CMS holds a PCH responsible for ALL data submission, even when contracting with a vendor.

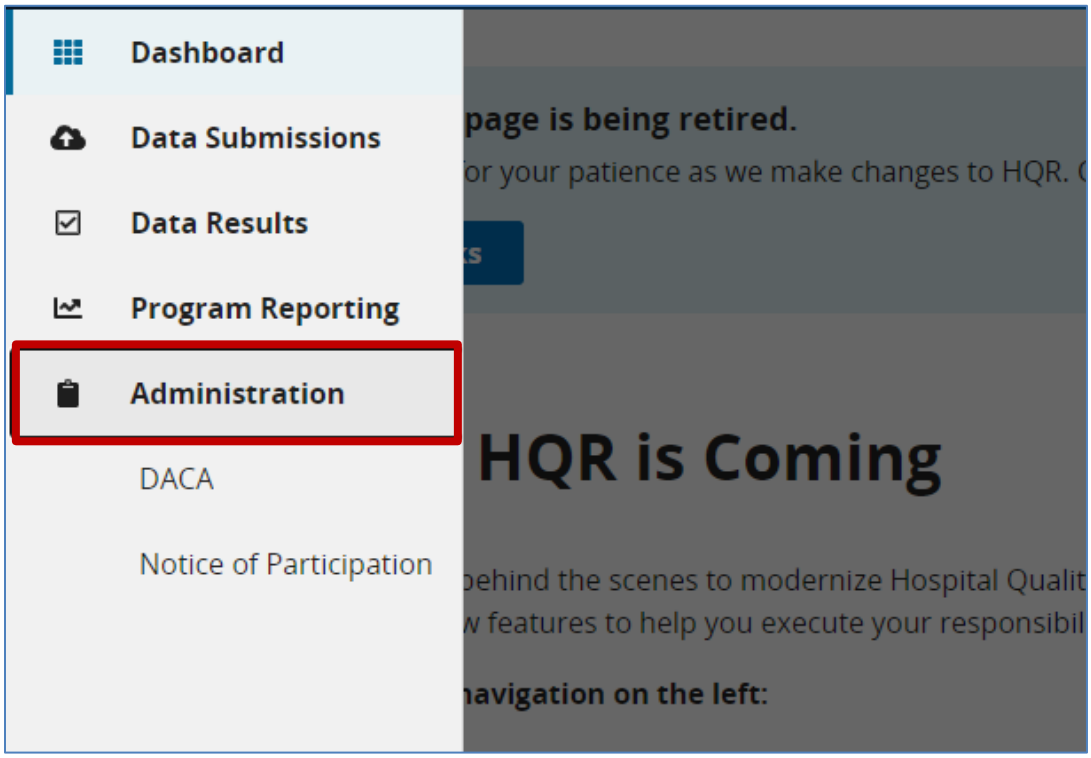
Vendors must be authorized to submit data on behalf of providers. To begin managing your vendors in the HQR System, follow these steps below:

1. Log in to HQR (https://hqr.cms.gov/hqrng/login) using our HARP user ID and password.
2. Go to **Administration**, then **Vendor Management.**
3. Once on the Vendor Management page, you can search for a Vendor, Add a Vendor, or view your Vendor(s).

Section 6: Notice of Participation (NOP)

The PCHs electing to participate in the PCHQR Program must complete a Notice of Participation (NOP) via the HQR System. Submission of the NOP is an indication that the PCH agrees to participate and publicly report its measure rates.

A direct link to manage the NOP is found on the HQR home page **Administration** link.

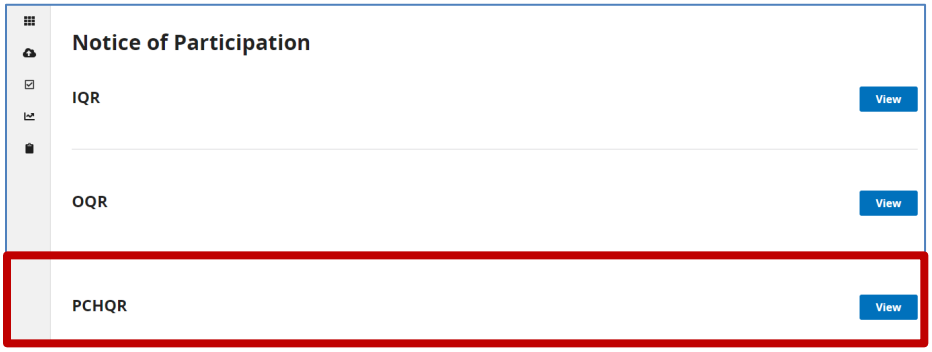


Note: Hospitals with a PCHQR Program NOP will remain active program participants until a withdrawal is submitted via the HQR System.

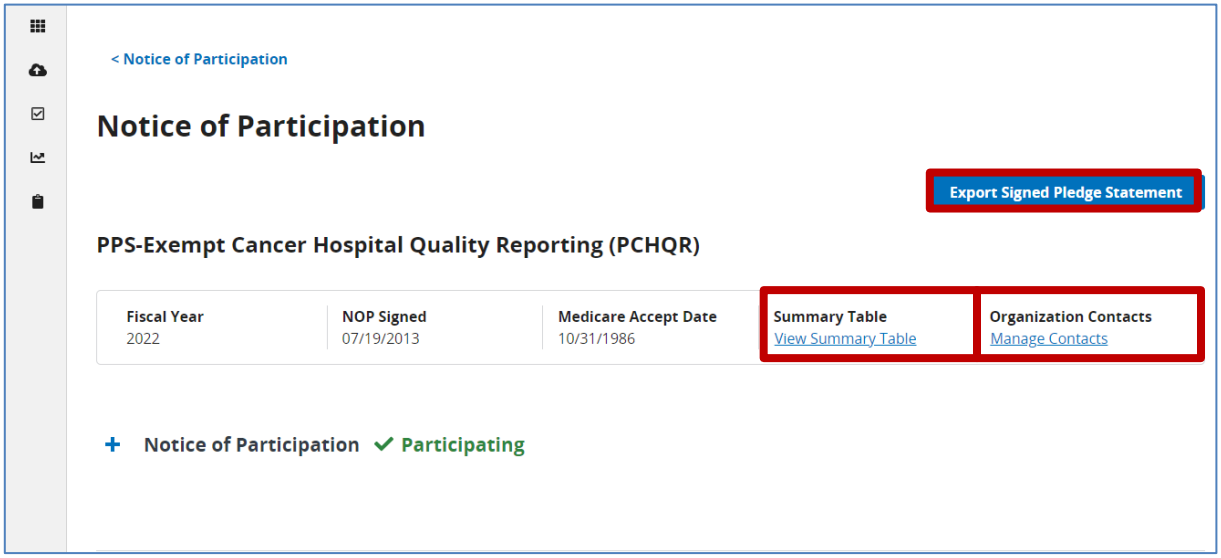
Accessing the Online NOP Application

To access the NOP application:

1. On the HQR NOP Page, if applicable, select **View** for PCHQR.



2. Access the Notice of Participation screen.



From this screen, you can select the following actions: **Export Signed Pledge Statement, View Summary Table,** and **Manage Contacts.**

3. Select an action to be completed:

- **View Summary Table** provides a summary of NOP statuses for a given fiscal year. As a PCHQR Program particiant, the NOP status of Participating carries forward each fiscal year.
- **Manage Contacts** displays the NOP contact table. Contact information is used for sending email alert notifications if edits are made within the NOP application.
- **Export Signed Pledge Statement** gives the option to print the signed, timestamped NOP.

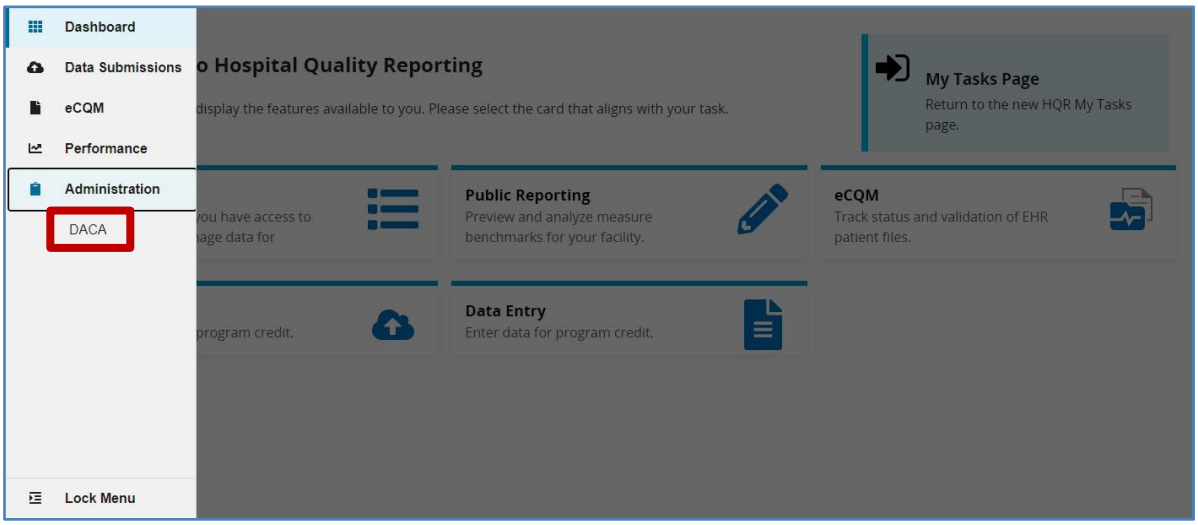
Section 7: Data Accuracy and Completeness Acknowledgement (DACA)

PCHs must complete an online DACA to attest to the accuracy and completeness of the entered data.

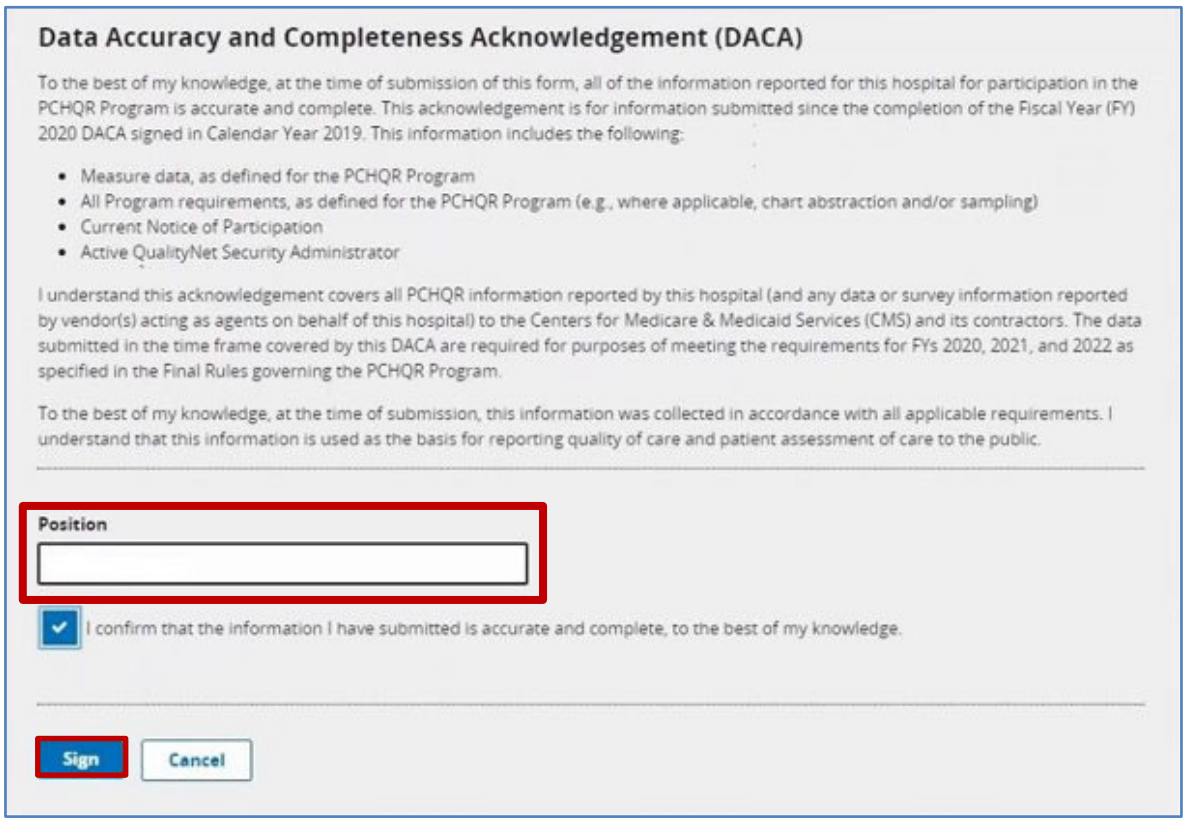
The DACA has an August 31 submission deadline for the next fiscal year. (The deadline is moved if August 31 falls on a Friday, Saturday, Sunday, or federal holiday). For FY 2026, the DACA should be submitted by September 2, 2025, via the HQR System. The DACA web application is usually accessible annually from July 1 through the submission deadline.

1. On the Hospital Quality Reporting home page navigation panel, select the **Administration (clipboard)** icon.

2. Select **DACA** from the navigation panel to begin the DACA submission process.



3. Review the DACA.



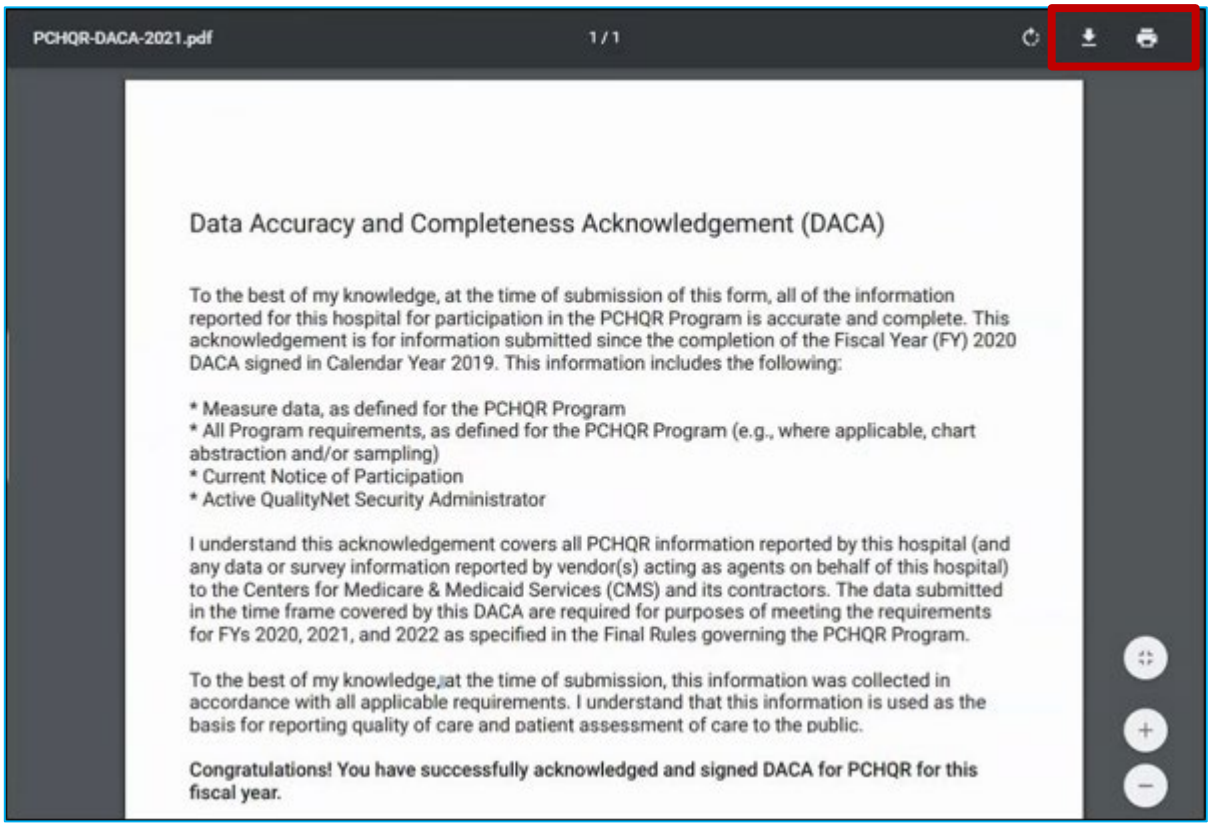
4. Enter your Position/Title in the text box.

5. Select: **"I confirm that the information I have submitted is accurate and complete, to the best of my knowledge."**

6. Click the **Sign** button to complete the DACA submission. Then you will receive a notification that you have successfully acknowledged and signed the DACA.

7. For a copy of the signed DACA, select **Export Signed DACA PDF**.

8. Select the option to Download or Print the PDF version located in the upper right-hand corner.



Section 8: Accessing and Reviewing Reports

The reports described in this section are helpful in monitoring a PCH's status as it relates to the PCHQR Program. The reports should be used as reference tools only.

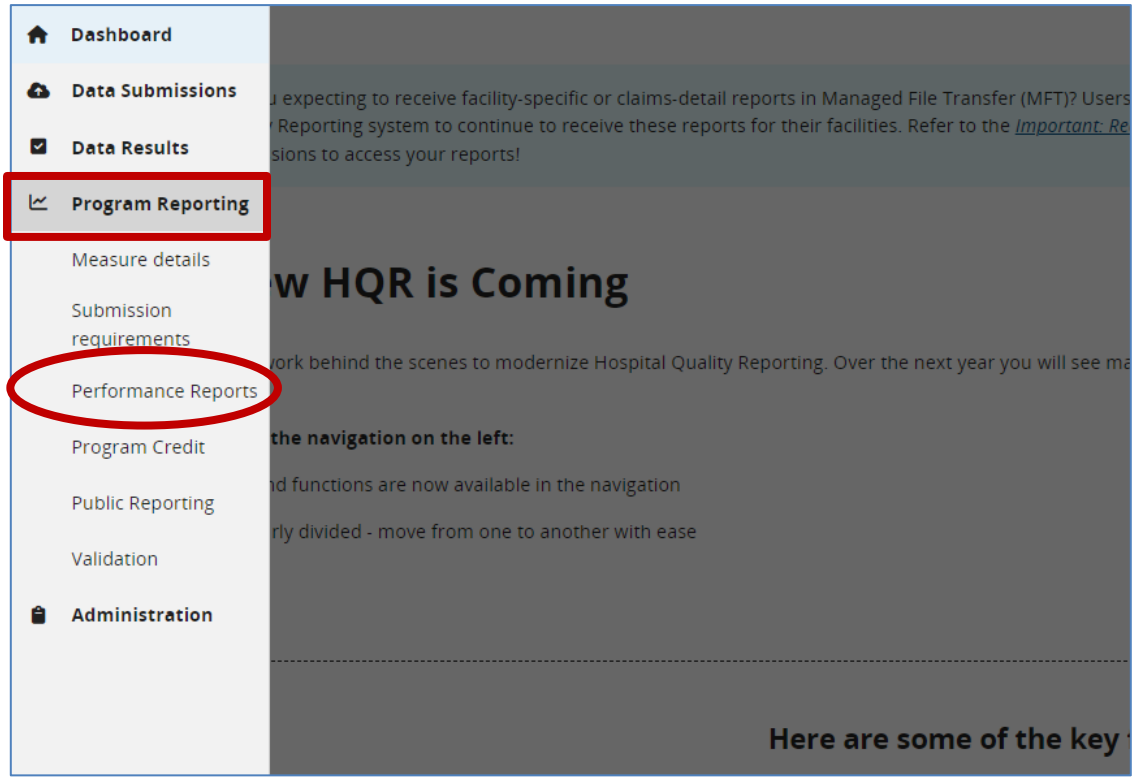
Types of Reports

PCHQR Performance Report

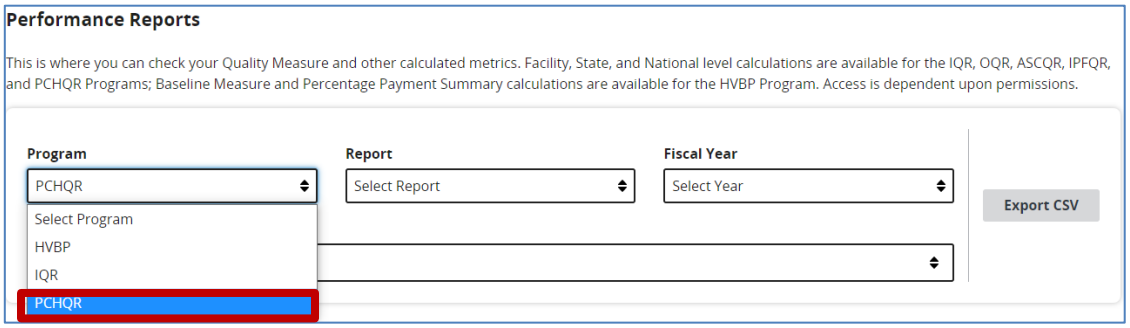
The facility report is specific to the facility accessing the report.

To run a PCHQR Performance Report:

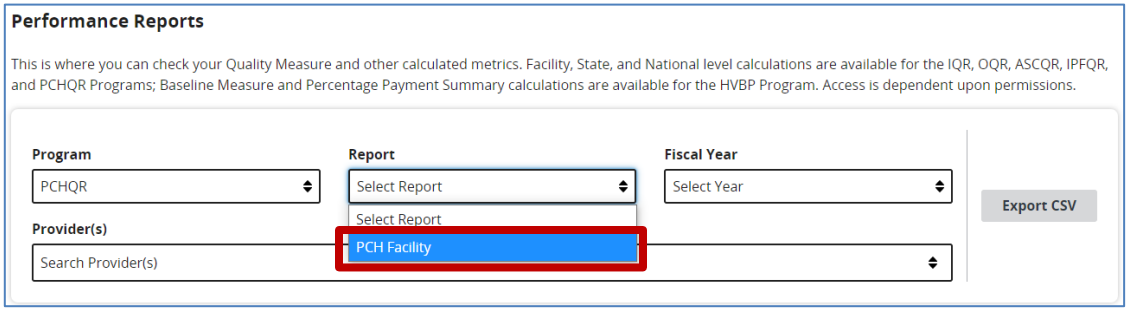
1. Select **Program Reporting** from the navigation panel to the left-hand side of the HQR landing page.



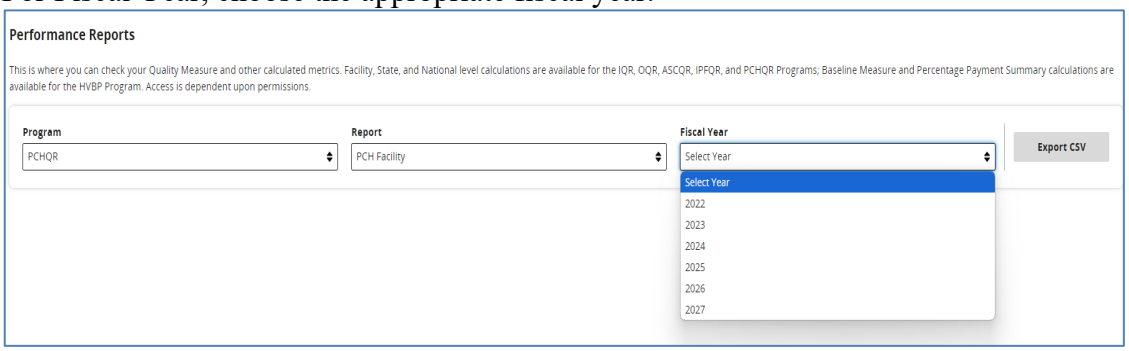
2. Select the **Performance Reports**.
3. For Program, choose **PCHQR**.



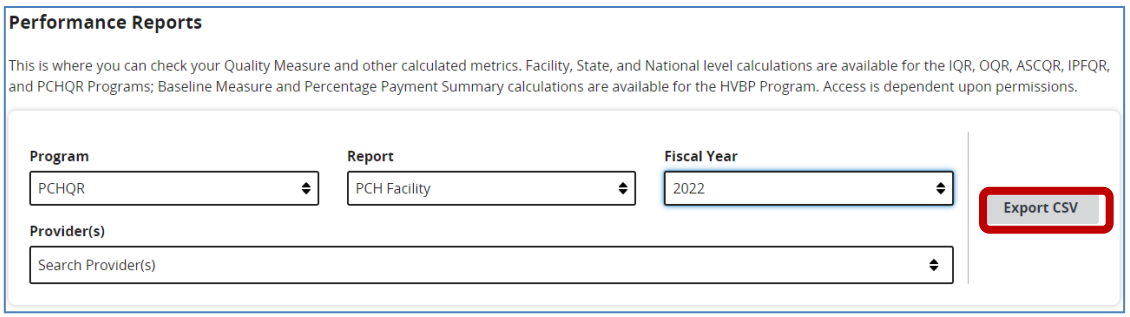
4. For Report, choose PCH Facility.



For Fiscal Year, choose the appropriate fiscal year.



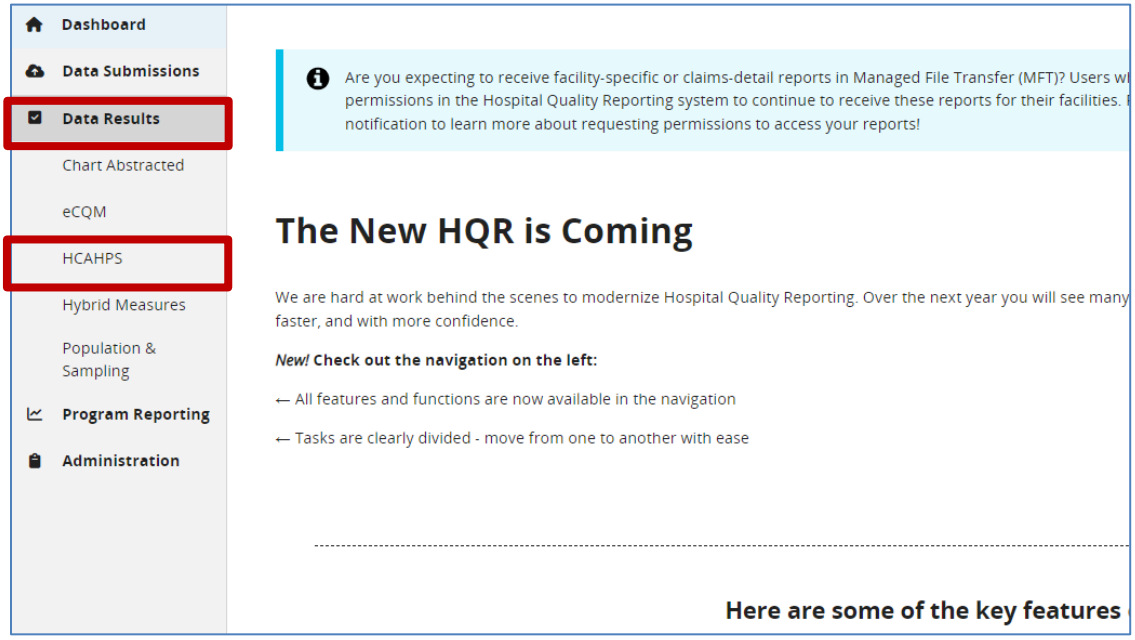
5. Select Export CSV. The CSV file will appear in a separate window to view, save, and/or print.



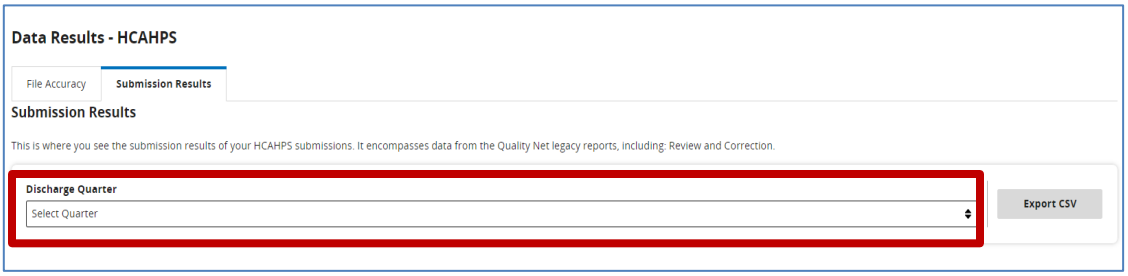
PCHQR Program HCAHPS Report

The PCHQR Program HCAHPS reports are accessed through the HQR **Data Results** functionality. To run a PCHQR Program HCAHPS Report:

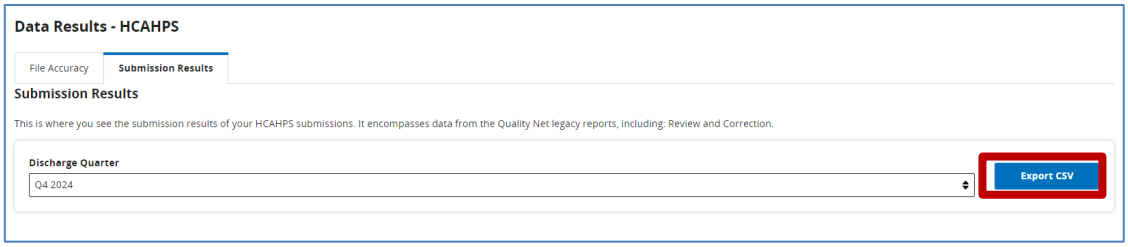
1. On the HQR home page menu, select the **Data Results** (checkbox) icon and then **HCAHPS**.



2. Select the applicable **Discharge Quarter** from the drop-down menu.



3. After selecting the appropriate discharge quarter, select **Export CSV.** Then**,** your facility's HCAHPS report will be displayed in a CSV format.



Section 9: Public Reporting

Background

Section 1866(k)(4) of the Social Security Act requires the Secretary of Health and Human Services to establish procedures for making the data submitted under the PCHQR Program available to the public.

Currently, PCH data are available to the public on the Provider Data Catalog on Data.cms.gov.

Care Compare on Medicare.gov and the data catalog on Data.cms.gov websites which publicly report hospital performance on numerous measures, are designed to make meaningful, relevant, and easily understood information about hospital performance accessible to the public and to inform and encourage hospitals' efforts to improve care quality. Accessibility and use of performance information spurs positive changes in healthcare delivery.

Public Display Timeline

The PCHQR Program has quality measure data publicly displayed on a rolling quarter basis for several measures; other measures are publicly displayed annually. The following table displays the upcoming public reporting releases and the PCHQR Program data that will be refreshed with each release. Prior data will continue to display until refreshed by newer data, then it will be archived. Archived data are located here: https://data.cms.gov/provider-data/archived-data/hospitals

PCHQR Program measures are often identified by a PCH numbering system:

PCH-4	CLABSI
PCH-5	CAUTI
PCH-6	SSI: Colon
PCH-7	SSI: Abdominal Hysterectomy
PCH-27	MRSA
PCH-26	CDI
PCH-28	Influenza Vaccination Coverage Among Healthcare Personnel (HCP)
PCH-29	HCAHPS
PCH-30/31	Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy
PCH-32/33/34/35	End of Life (EOL)
PCH-36	30-Day Unplanned Readmissions for Cancer Patients
PCH-37	Surgical Treatment Complications for Localized Prostate Cancer
PCH-38	COVID-19 Vaccination Coverage Among HCP

Provider Data Catalog Release	Measures	Quarters Displayed
January 2025	PCH-29	2Q, 3Q, 4Q 2023 and 1Q 2024
	PCH-4, PCH-5, PCH-6, PCH-7, PCH-26, and PCH-27	2Q, 3Q, 4Q 2023 and 1Q 2024
	PCH-38	1Q 2024
April 2025	PCH-29	3Q, 4Q 2023 and 1Q, 2Q 2024
	PCH-4, PCH-5, PCH-6, PCH-7, PCH-26, and PCH-27	3Q, 4Q 2023 and 1Q, 2Q 2024
	PCH-38	2Q 2024
July 2025	PCH-29	4Q 2023 and 1Q, 2Q, 3Q 2024
	PCH-4, PCH-5, PCH-6, PCH-7, PCH-26, and PCH-27	4Q 2023 and 1Q, 2Q, 3Q 2024

Provider Data Catalog Release	Measures	Quarters Displayed
	PCH-38	3Q 2024
	PCH-30, PCH-31	3Q, 4Q 2023 and 1Q, 2Q 2024
	PCH-32, PCH-33, PCH-34, PCH-35	3Q, 4Q 2023 and 1Q, 2Q 2024
	PCH-37	3Q, 4Q 2022 and 1Q, 2Q 2023

Based on the FY 2025 IPPS/LTCH PPS final rule, the following timeline has been established for future public reporting releases.

Summary of Public Display Requirements	
Measures	**Public Reporting Years**
Hospital Commitment to Health Equity (PCH-39)	January 2026 or as soon as feasible thereafter
Screening for Social Drivers of Health (PCH-40)	July 2027 or as soon as feasible thereafter
Screen Positive Rate for Social Drivers of Health (PCH-41 a-e[2])	July 2027 or as soon as feasible thereafter
Documentation of Goals of Care Discussions Among Cancer Patients (PCH-42)	July 2026 or as soon as feasible thereafter

Preview Period

Prior to the public release of data on the Provider Data Catalog, facilities are given the opportunity to preview data for 30 days. Preview data will be accessible via the HQR Public Reporting User Interface. Providers will be notified via ListServe when the preview data are available.

Please refer to the public reporting preview resources - PCHQR Program Preview Quick Reference Guide and Help Guide when made available.

Public Reporting (PR) User Interface (UI)

PR Data Details

Hospital Characteristics

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

Type of ownership is not publicly reported; however, this is publicly available in the downloadable database on the *Compare* tools.

If the displayed hospital characteristics are incorrect, your hospital should contact your state Certification and Survey Provider Enhanced Reports (CASPER) agency coordinator to correct the information. The state CASPER contact list is available from Care Compare on Medicare.gov by selecting the **Info for Health Care Providers** card, located at the bottom of the page under **Tips & Resources.** Select **Hospitals.** Once the screen refreshes, select the **State Survey Agency** at the top.

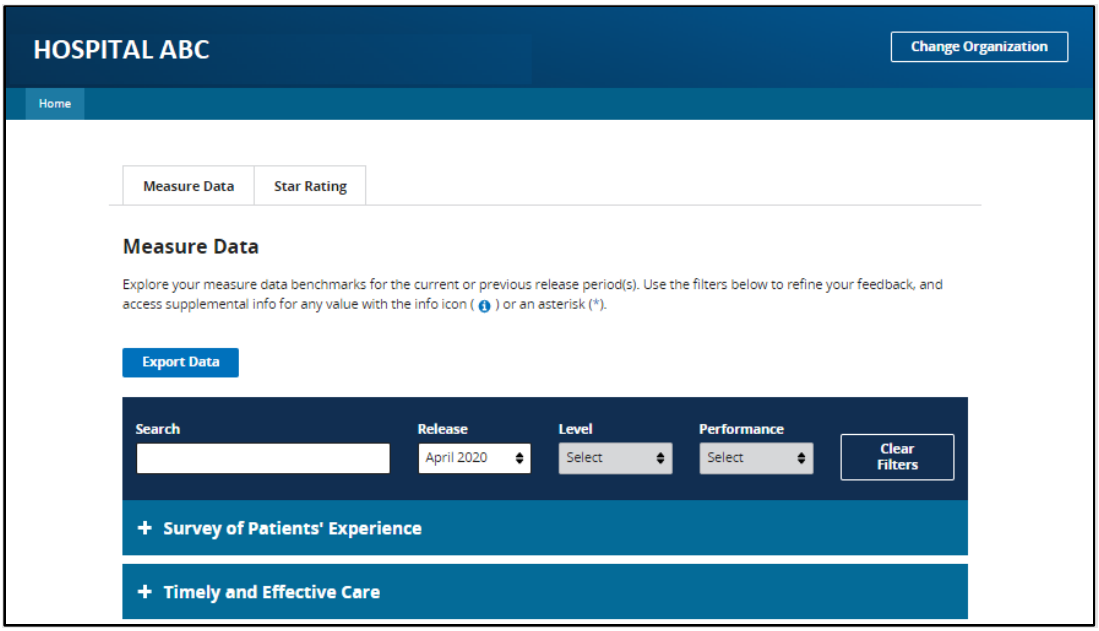
[2] The Screen Positive Rate for Social Drivers of Health measure has five individual HRSNs: 41a. Screen Positive Rate for Social Drivers of Health - Food Insecurity; 41b. Screen Positive Rate for Social Drivers of Health - Housing Instability; 41c. Screen Positive Rate for Social Drivers of Health - Transportation Needs; 41d. Screen Positive Rate for Social Drivers of Health - Utility Difficulties; 41e. Screen Positive Rate for Social Drivers of Health - Interpersonal Safety

If your hospital's state CASPER agency is unable to make the needed change, your hospital should contact its CMS regional office.

The measure IDs (e.g., PCH-1) which are displayed on the *Compare* tools, have been provided to assist in measure identification. However, neither will display on the Preview. The measure descriptions are modified for reporting purposes.

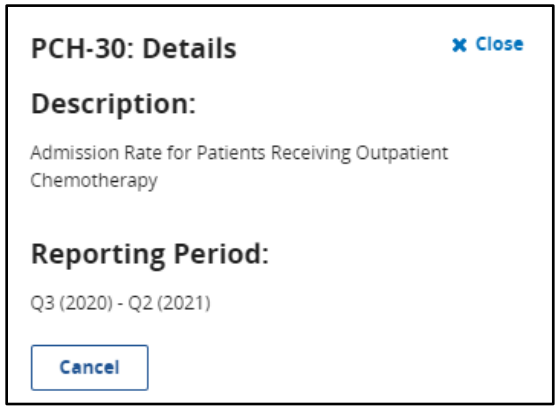
Measure Data Tab

The **Measure Data** tab will display accordions and measures based on the user's Hospital Quality Reporting (HQR) portal access.



The accordions can be expanded by selecting the (+) to the left of the title. Selecting the (-) will collapse the table. Once the accordion is expanded, the measures and data will display.

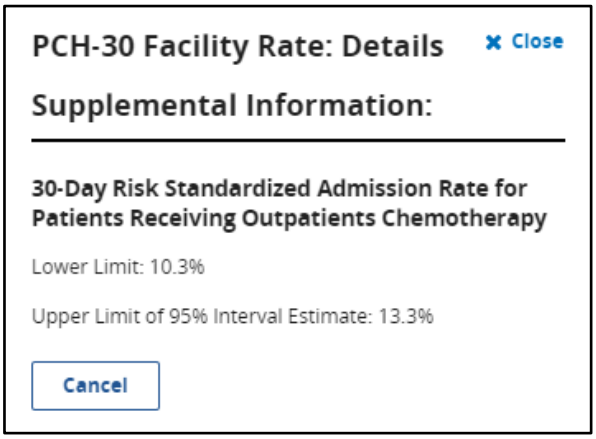
Select the info icon ( ) to the left of the measure ID to display the full measure description in a modal.

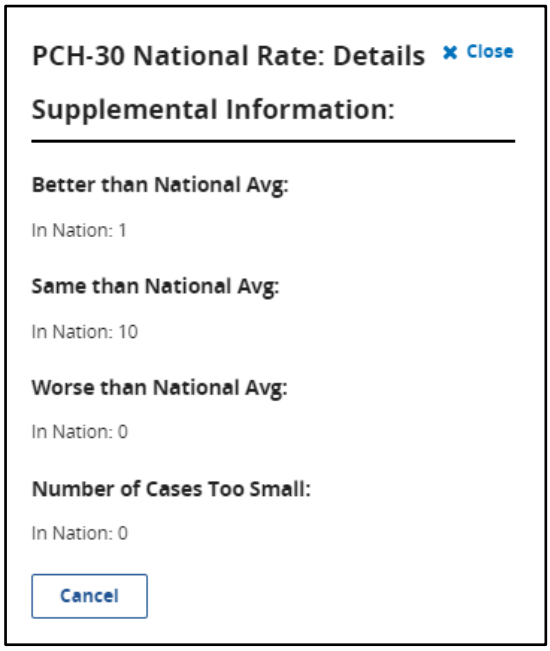


Data will display with an asterisk (*). Selecting the data value by the asterisk will pop up a modal

with additional details about the data, such as a footnote.

	Eligible Discharges	Facility Rate	National Rate	National Compare
PCH-30	2,959	11.7% *	12.6% *	SAME





Footnotes

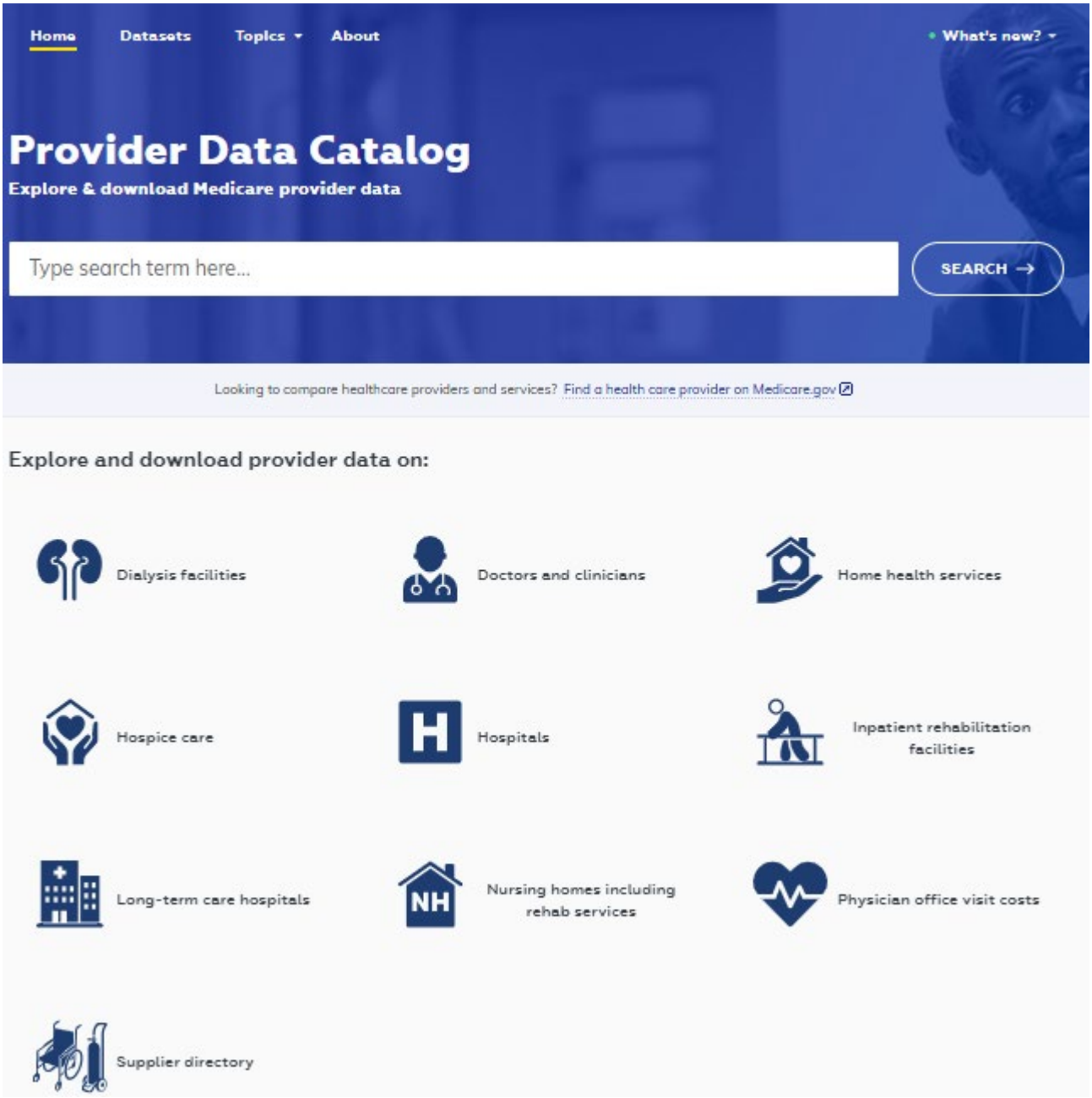
There are instances where footnotes are necessary to clarify data displayed in the preview report. Seven footnotes may be applicable for the PCHQR Program:

Footnote 1	The number of cases/patients is too few to report. This is applied to any measure rate where the numerator or denominator is greater than 0 and less than 11. Data will display on the preview report, but data ***will not*** display on the *Compare* tool.
Footnote 2	Data submitted were based on a sample of cases/patients
Footnote 3	Results are based on a shorter time period than required.
Footnote 5	Results are not available for this reporting period.
Footnote 7	No cases meet the criteria for this measure.
Footnote 12	This measure does not apply to this hospital for this reporting period.
Footnote 13	Results cannot be calculated for this reporting period.

Provider Data Catalog Website

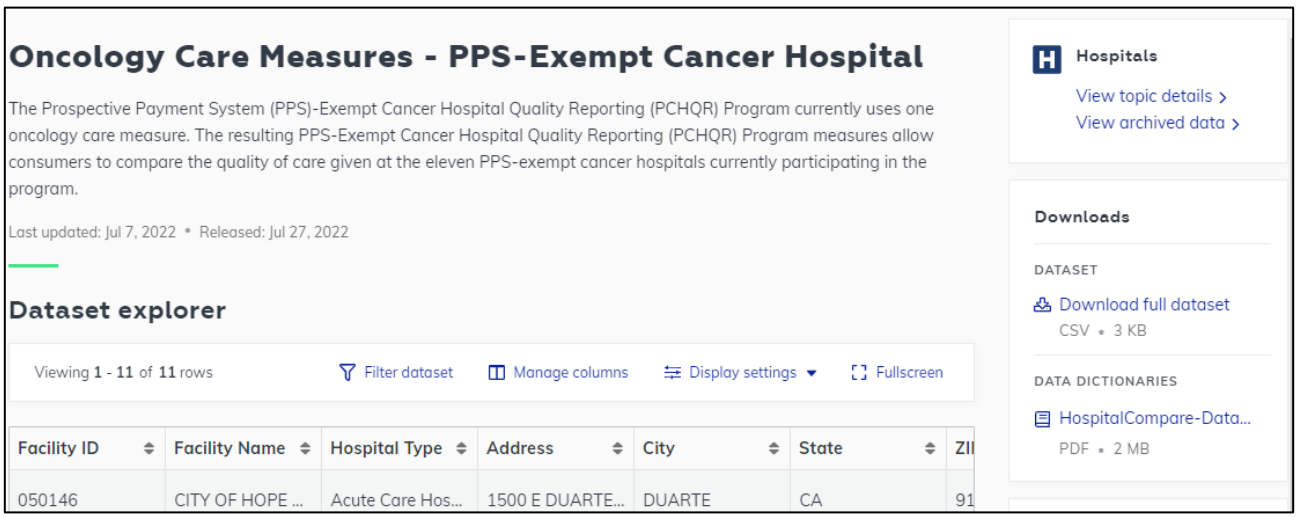
The direct link to the data catalog is https://data.cms.gov/provider-data/.

1. From the home page, there are two ways to locate PCHQR Program data:
    - Type "PCHQR" in the search box **or**
- Select the "**Hospitals**" card and type "PCHQR" in the search box



2. The search results will yield applicable PCH datasets to make a selection.

3. Once a measure selection is made, the **Dataset Explorer** table is avaiable to view.



4. Scroll across the page to see the associated data results. There is also an option to download the dataset in a different format, such as CSV.

   The data displayed on the data catalog on Data.cms.gov are public. You, other PCHQR Program participants, patients, and providers can see your data and the data from other PCHs.

   For PCHs, one of these four footnotes might display:

   Footnote 1 The number of cases/patients is too few to report. This is applied to any measure rate where the numerator or denominator is greater than 0 and less than 11. Data will display on the preview report, but data ***will not*** display on the *Compare* tool.

   Footnote 2 Data submitted were based on a sample of cases/patients.

   Footnote 3 Results are based on a shorter time period than required.

   Footnote 5 Results are not available for this reporting period.

   Footnote 7 No cases meet the criteria for this measure.

   Footnote 12 This measure does not apply to this hospital for this reporting period.

   Footnote 13 Results cannot be calculated for this reporting period.

Section 10: Resources

The following information contains additional resources available for PCHs participating in the CMS PCHQR Program.

QualityNet Website

Established by CMS, QualityNet provides healthcare quality improvement news, resources, and data reporting tools and applications used by healthcare providers and others. QualityNet is the only CMS-approved website for secure communications and healthcare quality data exchange between quality improvement organizations, hospitals, physician offices, nursing homes, end-stage renal disease networks and facilities, and data vendors.

The PCHQR Program uses QualityNet to publish information, including requirements, announcements about educational offerings, and news stories. PCHQR Program home page link: https://qualitynet.cms.gov/pch/pchqr.

The QualityNet home page (https://qualitynet.cms.gov/) will offer user guides for the HQR System and HQR System reports. Links are located on the Training and Guides page at https://qualitynet.cms.gov/training-guides#tab2.

Quality Reporting Center Website

For additional resources and tools, users can access the website http://www.QualityReportingCenter.com. Data collection tools, timelines, calendars, and other valuable resources can be located on this website. In the dropdown menu for the **Inpatient** tab, select the **PCHQR Program**.

National Provider Webinars are provided on a routine basis. The slides from each of the education sessions are published to the QualityNet website and are available for review under the *PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)* tab
by selecting the **Webinars/Calls** link from the drop-down menu.

PCHQR Program ListServe

To receive important PCHQR Program updates and notifications, please subscribe to the ListServes on the QualityNet website. On the left side of the page, click the *Subscribe to Email Updates* button and complete the required user Information; check the box next to *PPS-Exempt Cancer Hospital Quality Reporting Program*, select any other notifications desired, and click **Submit**.

Questions and Answers (Q&A)

The Quality Q&A Tool is also a good resource for program information. The tool is intended to help users quickly find program answers. The Q&A Tool can be accessed from the QualityNet home page **Help** drop-down menu at the top of the page. Select the **PPS-Exempt Cancer Hospitals** link under the Quality Question and Answer Tool header. The direct link is https://cmsqualitysupport.servicenowservices.com/qnet_qa

If needed information is not found in the Quality Q&A Tool, select the **Ask a Question** link to submit a question to the PCHQR Program SC or call, toll-free, (844) 472-4477 or (866) 800-8765, between the hours of 8 a.m. and 8 p.m. ET (5 a.m. to 5 p.m. PT).

CCSQ Service Center

For technical issues contact the CCSQ Service Center call toll-free (866) 288-8912 between the hours of 8 a.m. and 8 p.m. ET, or email qnetsupport@cms.hhs.gov.

Paper Abstraction Tools

Paper abstraction tools have been developed for PCHs to use as an optional mechanism to aid in the collection of the measure data for the CMS PCHQR Program. The data collection tools are located under the *Data Collection Overview* section at https://qualitynet.cms.gov/pch/data-management/data-collection

Appendix A: PCHQR Program Measure Submission Deadlines by Due Date

Data must be submitted no later than 11:59 p.m. PT on the submission deadline. Only data submitted according to CMS established deadlines qualify for inclusion in the PCHQR Program. The reference periods noted for CLABSI, CAUTI, SSI, MRSA Bacteremia, and CDI refer to event dates; the reference periods for the other measures denote designated measure periods (patient visit, discharge date, etc.). For complete measure titles and CBE designations, please visit the QualityNet PCHQR Program Measures web page.

This provides specific measures with their CBE and PCH numbers, the program (fiscal) year to which the measure applies, reporting periods that apply to each respective program (fiscal) year, quarterly data submission deadlines for each reporting period, and time frames when each metric will be displayed for Public Reporting on the data catalog on Data.cms.gov. Gray boxes to indicate activity complete

Program (Fiscal) Years	Reporting Periods– Calendar Year (CY) Quarters (Qs)	Quarterly Data Submission Deadlines	Data Catalog Release October 2024	Data Catalog Release January 2025	Data Catalog Release April 2025	Data Catalog Release July 2025	Data Catalog Release October 2025	Data Catalog Release January 2026	Data Catalog Release April 2026	Data Catalog Release July 2026	Data Catalog Release October 2026	Data Catalog Release January 2027	Data Catalog Release April 2027	Data Catalog Release July 2027	Data Catalog Release October 2027
2024	1Q 2023	PRIOR	1Q 2023– 4Q 2023												
	2Q 2023	PRIOR		2Q 2023– 1Q 2024											
	3Q 2023	PRIOR			3Q 2023– 2Q 2024										
	4Q 2023	PRIOR				4Q 2023– 3Q 2024									
2025	1Q 2024	PRIOR					1Q 2024– 4Q 2024								
	2Q 2024	11/18/2024						2Q 2024- 1Q 2025							
	3Q 2024	02/17/2025							3Q 2024- 2Q 2025						
	4Q 2024	05/15/2025								4Q 2024- 3Q 2025					
2026	1Q 2025	08/18/2025									1Q 2025- 4Q 2025				
	2Q 2025	11/17/2025										2Q 2025 – 1Q 2026			
	3Q 2025	02/17/2026											3Q 2025- 2Q 2026		
	4Q 2025	05/18/2026												4Q 2025 – 3Q 2026	
2027	1Q 2026	08/17/2026													1Q 2026 – 4Q 2026
	2Q 2026	11/16/2026													
	3Q 2026	02/16/2027													
	4Q 2026	05/17/2026													

Safety and HAI Surgical Site Infection (SSI) CBE #0753 PCH–6 (colon) PCH–7 (abdominal hysterectomy)	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters (Qs)	Quarterly Data Submission Deadlines	Data Catalog Release October 2024	Data Catalog Release January 2025	Data Catalog Release April 2025	Data Catalog Release July 2025	Data Catalog Release October 2025	Data Catalog Release January 2026	Data Catalog Release April 2026	Data Catalog Release July 2026	Data Catalog Release October 2026
	2025	1Q 2023	PRIOR	1Q 2023–4Q 2023								
		2Q 2023	PRIOR		2Q 2023–1Q 2024							
		3Q 2023	PRIOR			3Q 2023 – 2Q 2024						
		4Q 2023	PRIOR				4Q 2023 – 3Q 2024					
	2026	1Q 2024	PRIOR					1Q 2024–4Q 2024				
		2Q 2024	11/18/2024						2Q 2024 – 1Q 2025			
		3Q 2024	02/17/2025							3Q 2024 – 2Q 2025		
		4Q 2024	05/15/2025								4Q 2024 – 3Q 2025	
	2027	1Q 2025	08/18/2025									1Q 2025 – 4Q 2025
		2Q 2025	11/17/2025									
		3Q 2025	02/17/2026									
		4Q 2025	05/18/2026									

Safety and HAI *Clostridioides difficile* Infection (CDI) CBE #1717 (PCH–26) Methicillin-resistant *Staphylococcus aureus* (MRSA) CBE #1716 (PCH–27)	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters (Qs)	Quarterly Data Submission Deadlines	Data Catalog Release October 2024	Data Catalog Release January 2025	Data Catalog Release April 2025	Data Catalog Release July 2025	Data Catalog Release October 2025	Data Catalog Release January 2026	Data Catalog Release April 2026	Data Catalog Release July 2026	Data Catalog Release October 2026
	2025	1Q 2023	PRIOR	1Q 2023–4Q 2023								
		2Q 2023	PRIOR		2Q 2023–1Q 2024							
		3Q 2023	PRIOR			3Q 2023–2Q 2024						
		4Q 2023	PRIOR				4Q 2023–3Q 2024					
	2026	1Q 2024	PRIOR					1Q 2024–4Q 2024				
		2Q 2024	11/18/2024						2Q 2024 – 1Q 2025			
		3Q 2024	02/17/2025							3Q 2024 – 2Q 2025		
		4Q 2024	05/15/2025								4Q 2024 – 3Q 2025	
	2027	1Q 2025	08/18/2025									1Q 2025 – 4Q 2025
		2Q 2025	11/17/2025									
		3Q 2025	02/17/2026									
		4Q 2025	05/18/2026									

Safety and HAI	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters (Qs)	Quarterly Data Submission Deadlines	Data Catalog Release January, April, And July 2024	Data Catalog Release October 2024	Data Catalog Release January, April, And July 2025	Data Catalog Release October 2025	Data Catalog Release January, April, And July 2026	Data Catalog Release October 2026
Influenza Healthcare Personnel (HCP) Vaccination CBE #0431 (PCH-28)	**2025**	4Q 2023	PRIOR		4Q 2023–1Q 2024				
		1Q 2024							
	2026	4Q 2024	05/15/2025				4Q 2024–1Q 2025		
		1Q 2025							
	2027	4Q 2025	05/18/2026						4Q 2025–1Q 2026
		1Q 2026							

Safety and HAI	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters (Qs)	Quarterly Data Submission Deadlines	Data Catalog Release October 2024	Data Catalog Release January 2025	Data Catalog Release April 2025	Data Catalog Release July 2025	Data Catalog Release October 2025	Data Catalog Release January 2026	Data Catalog Release April 2026	Data Catalog Release July 2026	Data Catalog Release October 2026
COVID-19 HCP Vaccination (PCH-38)	**2025**	4Q 2023	PRIOR	4Q 2023								
	2026	1Q 2024	PRIOR		1Q 2024							
		2Q 2024	11/18/2024			2Q 2024						
		3Q 2024	02/17/2025				3Q 2024					
		4Q 2024	05/15/2025					4Q 2024				
	2027	1Q 2025	08/18/2025						1Q2025			
		2Q 2025	11/17/2025							2Q 2025		
		3Q 2025	02/17/2026								3Q 2025	
		4Q 2025	05/18/2026									4Q 2025

Safety and HAI	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters (Qs)	Quarterly Data Submission Deadlines	Data Catalog Release October 2024	Data Catalog Release January 2025	Data Catalog Release April 2025	Data Catalog Release July 2025	Data Catalog Release October 2025	Data Catalog Release January 2026	Data Catalog Release April 2026	Data Catalog Release July 2026	Data Catalog Release October 2026
Patient Safety Structural Measure (PCH-43)	**2027**	1Q 2025	05/18/2026	In the FY 2025 Inpatient Prospective Payment Systems (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (69455-69488), public reporting is anticipated to begin in Fall 2026 or as soon as feasible thereafter.								
		2Q 2025										
		3Q 2025										
		4Q 2025										

Clinical Process/ Oncology Care Measures (Claims-Based)	Program (Fiscal) Years	Reporting Periods	Data Catalog Release July 2025	Data Catalog Release October 2025, January, and April 2026	Data Catalog Release July 2026
End of Life (EOL)-Chemo CBE #0210 (PCH-32) EOL-Hospice CBE #0215 (PCH-34)	**2026**	Data from 7/1/2023 through 6/30/2024	3Q 2023-2Q 2024		
	2027	Data from 7/1/2024 through 6/30/2025			3Q 2024-2Q 2025

Note: EOL-Chemo=Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life
EOL-Hospice=Proportion of Patients Who Died from Cancer Not Admitted to Hospice

Intermediate Clinical Outcome Measures (Claims-Based)	Program (Fiscal) Years	Reporting Periods	Data Catalog Release July 2025	Data Catalog Release October 2025, January, and April 2026	Data Catalog Release July 2026
EOL-ICU CBE #0213 (PCH–33) EOL-3DH CBE #0216 (PCH–35)	**2026**	Data from 7/1/2023 through 6/30/2024	3Q 2023-2Q 2024		
	2027	Data from 7/1/2024 through 6/30/2025			3Q 2024-2Q 2025

Note: EOL-ICU=Proportion of Patients Who Died from Cancer Admitted to the intensive care unit in the Last 30 Days of Life
EOL-3DH=Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days

Patient Engagement/ Experience of Care	Program (Fiscal) Years	Reporting Periods– Calendar Year Quarters (Qs)	Quarterly Data Submission Deadlines	Data Catalog Release October 2024	Data Catalog Release January 2025	Data Catalog Release April 2025	Data Catalog Release July 2025	Data Catalog Release October 2025	Data Catalog Release January 2026	Data Catalog Release April 2026	Data Catalog Release July 2026	Data Catalog Release October 2026
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey CBE #0166 (PCH-29)	**2025**	1Q 2023	PRIOR	1Q 2023 – 4Q 2023	2Q 2023 – 1Q 2024	3Q 2023 – 2Q 2024	4Q 2023 – 3Q 2024	1Q 2024 – 4Q 2024	2Q 2024- 1Q 2025	3Q 2024 – 2Q 2025	4Q 2024 – 3Q 2025	1Q 2025 – 4Q 2025
		2Q 2023	PRIOR									
		3Q 2023	PRIOR									
		4Q 2023	PRIOR									
	2026	1Q 2024	PRIOR									
		2Q 2024	10/02/2024									
		3Q 2024	01/02/2025									
		4Q 2024	04/02/2025									
	2027	1Q 2025	07/02/2025									
		2Q 2025	10/01/2025									
		3Q 2025	01/07/2026									
		4Q 2025	04/01/2026									

	Program (Fiscal) Years	Reporting Periods– Calendar Year Quarters (Qs)	Quarterly Data Submission Deadlines	Data Catalog Release January 2026	Data Catalog Release April 2026	Data Catalog Release July 2026	Data Catalog Release October 2026
of Goals of Care Discussions Among Cancer Patients (PCH-42)	**2026**	1Q 2024	08/18/2025	In the FY 2024 Inpatient Prospective Payment Systems (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (59223 and 59226-59228), public reporting is anticipated to begin July 2026 or as soon as feasible thereafter.			
		2Q 2024					
		3Q 2024					
		4Q 2024					
	2027	1Q 2026	08/17/2026				
		2Q 2026					
		3Q 2026					
		4Q 2026					

Health Equity Measures Hospital Commitment to Health Equity (PCH-39)	**Program (Fiscal) Years**	**Reporting Periods– Calendar Year Quarters (Qs)**	**Quarterly Data Submission Deadlines**	**Data Catalog Release January 2026**	**Data Catalog Release April 2026**	**Data Catalog Release July 2026**	**Data Catalog Release October 2026**	
	2026	1Q 2024	08/18/2025	In the FY 2025 IPPS/LTCH PPS final rule (69579–69580), public reporting is anticipated to begin with CY 2024 data beginning January 2026 or as soon as feasible thereafter.				
		2Q 2024						
		3Q 2024						
		4Q 2024						
	2027	1Q 2025	08/17/2026					
		2Q 2025						
		3Q 2025						
		4Q 2025						

Health Equity Measures Screening for Social Drivers of Health (PCH-40) Screen Positive Rate for Social Drivers of Health (PCH-41a–e*)	**Program (Fiscal) Years**	**Reporting Periods– Calendar Year Quarters (Qs)**	**Quarterly Data Submission Deadlines**	**Data Catalog Release October 2024**	**Data Catalog Release January 2025**	**Data Catalog Release April 2025**	**Data Catalog Release July2025**	**Data Catalog Release October 2025**
	2026**	1Q 2024	08/18/2025	In the FY 2024 IPPS/LTCH PPS final rule (59216, 59221–59222, 59226–59228), public reporting is anticipated to begin with CY 2024 data beginning July 2027 or as soon as feasible thereafter.				
		2Q 2024						
		3Q 2024						
		4Q 2024						
	2027	1Q 2025	08/17/2026					
		2Q 2025						
		3Q 2025						
		4Q 2025						

*The Screen Positive Rate for Social Drivers of Health measure has five individual Health-related Social Needs: 41a. Screen Positive Rate for Social Drivers of Health - Food Insecurity; 41b. Screen Positive Rate for Social Drivers of Health - Housing Instability; 41c. Screen Positive Rate for Social Drivers of Health - Transportation Needs; 41d. Screen Positive Rate for Social Drivers of Health - Utility Difficulties; 41e. Screen Positive Rate for Social Drivers of Health - Interpersonal Safety

** In the FY 2024 IPPS/LTCH PPS final rule (59215 and 59221), FY 2026 data reporting is voluntary.

Claims Based Outcome Measure Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy Risk-Standardized Admission Rate (RSAR) PCH-30 Risk-Standardized ED Visit Rate (RSEDR) PCH-31	**Program (Fiscal) Years**	**Reporting Periods**	**Data Catalog Release October 2024 And January, April 2025**	**Data Catalog Release July 2025**	**Data Catalog Release October 2024 And January, April 2026**	**Data Catalog Release July 2026**
	2026	Data from 07/01/2023 through 06/30/2024		3Q 2023–2Q 2024		
	2027	Data from 07/01/2024 through 06/30/2025				3Q 2024–2Q 2025

Claims-Based Outcome Measure	Program (Fiscal) Years	Reporting Periods	Data Catalog Release October 2024	Data Catalog Release January, April, July 2025	Data Catalog Release October 2025	Data Catalog Release January, April, July 2026	Data Catalog Release October 2026
30-Day Unplanned Readmissions for Cancer Patients CBE #3188 (PCH-36)	**2025**	Data from 10/1/2022 through 09/30/2023	4Q 2022–3Q 2023				
	2026	Data from 10/1/2023 through 09/30/2024			4Q 2023–3Q 2024		
	2027	Data from 10/1/2024 through 09/30/2025					4Q 2024–3Q 2025

Claims-Based Outcome Measure	Program (Fiscal) Years	Reporting Periods	Data Catalog Release October 2024 And January, April 2025	Data Catalog Release July 2025	Data Catalog Release October 2024 And January, April 2026	Data Catalog Release July 2026
Surgical Treatment Complications for Localized Prostate Cancer (PCH-37)	**2026**	Data from 07/01/2022 through 06/30/2023		3Q 2022–2Q 2023		
	2027	Data from 07/01/2023 through 06/30/2024				3Q 2023–2Q 2024

Appendix B: Glossary of Terms

Aggregate (data): Aggregate data are elements derived for a specific hospital from the results of each measures algorithm over a given period of time period (e.g., quarterly).

Algorithm: An algorithm is an ordered sequence for data element retrieval and aggregation through which numerators and denominators are identified.

Calendar Year: A calendar year is the time period between January 1 and December 31 of a given year.

Consensus-Based Entity (CBE): The CMS CBE endorses quality measures through a transparent, consensus-based process that incorporates feedback from diverse groups of stakeholders to foster health care quality improvement. The CMS CBE endorses measures only if they pass measure evaluation criteria: importance to measure and report, scientific acceptability of measure properties[1], feasibility[1], usability and use[1], and related[1] and competing measures[1].

Data Accuracy and Completeness Acknowledgement (DACA): The DACA is a requirement for facilities participating in the PCHQR Program. The DACA is an electronic acknowledgement, which indicates that the data provided to meet the annual payment update (APU) data submission requirements are accurate and complete to the best of the facility's knowledge at the time of data submission.

Data Collection: Data collection is the act or process of capturing raw or primary data from a single or number of sources; also called “data gathering.”

Denominator: The denominator is the lower part of a fraction used to calculate a rate, proportion, or ratio.

Excluded Populations: Excluded Populations are based on detailed information describing the populations that should not be included in the indicator. For example, specific age groups, International Classification of Diseases (ICD) procedure or diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

Initial Patient Populations: Initial Patient Populations are based on detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups, diagnoses, ICD diagnostic and procedure codes, Current Procedural Terminology (CPT) codes, revenue codes, enrollment periods, insurance, and health plan groups, etc.

Format: Format specifies the character length of a specific data element, the type of information the data element contains (i.e., numeric, decimal, number, date, time, character, or alphanumeric), and the frequency with which the data element occurs.

Measure Information Form: This tool provides specific clinical and technical information on a measure. The information contained includes measure set, performance measure name, description, rationale, type of measure, improvement noted as, numerator/ denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, data collection approach, data accuracy, measure analysis suggestions, sampling, data reported as, and selected references.

Medical Record (Data Source): A medical record is the source of data obtained from the documentation maintained on a patient in any healthcare setting (e.g., hospital, home care, long-term care, practitioner's office), including automated and paper medical record systems.

Notice of Participation (NOP): A requirement for PCHQR Program participating facilities, the NOP indicates a facility's agreement to participate in the Program and to allow public reporting of its measure rates. The NOP has three options: agree to participate, do not agree to participate, and request to be withdrawn from participation.

Numerator: The numerator is the upper portion of a fraction used to calculate a rate, proportion, or ratio.

Patient Level Data: The phrase "patient level data" refers specifically to the collection of data elements that depict the healthcare services provided to an individual patient. Patient level data are aggregated to generate data at the setting level (e.g., hospital) and/or comparison group data.

Process: Here, the term "process" refers to an interrelated series of events, activities, actions, mechanisms, or steps that transform inputs into outputs.

Program Year: The term "Program Year," in the PCHQR Program, is equivalent to a given fiscal year. Each calendar year is connected to a specific program (fiscal) year.

Reporting Period: The reporting period is the defined timeframe during which medical records are to be reviewed.

Sampling Method: The sampling method is essentially the process used to select a sample. Sampling approaches for the PCHQR Program are simple random sampling and systematic random sampling.

Sampling Size: The sampling size refers to the number of individuals or particular patients included.

Simple Random Sample: A "Simple Random Sample" is a selection of patients from the total population that is processed in a way that every case has a similar chance of being selected.

Strata: See "Stratified Measure" below.

Stratified Measure: A stratified measure is used to assist in analysis and interpretation that is classified into a number of categories. The overall or un-stratified measure evaluates all the strata together. A stratified measure, or each stratum, consists of a subset of the overall measure. For example, the OCMs are stratified by quarter.

Systematic Random Sampling: Systematic random sampling is a process in which the starting case is selected randomly, and the next cases are selected according to a fixed interval based upon the number of cases in the population.