PPS-Exempt Cancer Hospital Quality Reporting Program Manual

Updated April 2019

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Section 1: PPS-Exempt Cancer Hospital Quality Reporting Program

Overview

The PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program was established by Section 3005 of the Affordable Care Act, which added subsections (a)(1)(W) and (k) to section 1866 of the Social Security Act. Section 1866(k) of the Act establishes a quality reporting program for hospitals described in section 1886(d)(1)(B)(v) of the Act. These hospitals 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 inpatient care provided to Medicare beneficiaries by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care.

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

Eligible hospitals are described in section 1886(d)(1)(B)(v) and referred to as PPS-Exempt Cancer Hospitals (PCHs). These hospitals are excluded from payment under the IPPS. Eleven hospitals have been granted the PPS-Exempt Cancer Hospital designation by the Centers for Medicare & Medicaid Services (CMS). 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.

Hospital Inpatient Prospective Payment Systems (IPPS) Final Rule

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. Information regarding the PCHQR Program can be found in the following final rule publications:

- In the Fiscal Year (FY) 2013 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) Final Rule, CMS finalized five quality measures for the FY 2014 program and subsequent years. Two Safety and Healthcare-associated Infection (HAI) and three Cancer-Specific Treatment (CST) measures comprise the five measures added. Information for the PCHQR Program is contained on pages 53555–53567 in the *Federal Register*/Vol. 77, No. 170, published August 31, 2012. The direct download (12.8 MB) can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf.

- In the FY 2014 IPPS/LTCH PPS Final Rule, CMS finalized one additional new HAI quality measure for the FY 2015 program and subsequent years: Surgical Site Infection (SSI). In addition, CMS finalized 12 new quality measures, including five clinical process Oncology Care Measures (OCMs), six Surgical Care Improvement Project (SCIP) measures, and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey for

the FY 2016 program and subsequent years. CMS did not remove or replace any of the previously finalized measures from the PCHQR Program for FY 2015 and FY 2016. Information for the PCHQR Program is contained on pages 50837–50853 in the *Federal Register*/Vol. 78, No. 160, published August 19, 2013. The direct download (12.5 MB) can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf.

- In the FY 2015 IPPS/LTCH PPS Final Rule, CMS finalized one new clinical effectiveness measure for the FY 2017 program and subsequent years: External Beam Radiotherapy for Bone Metastases (EBRT). CMS did not remove or replace any of the previously finalized measures from the PCHQR Program for the FY 2017 program and subsequent years. Information for the PCHQR Program is contained on pages 50277–50286 in the *Federal Register*/Vol. 79, No. 163, published August 22, 2014. The direct download (5.78 MB) can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf.

- In the FY 2016 IPPS/LTCH PPS Final Rule, CMS adopted three new HAI measures collected via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) and removed the six SCIP measures from the PCHQR Program for the FY 2018 program and subsequent years. Information for the PCHQR Program is contained on pages 49713–49723 in the *Federal Register*/Vol. 80, No. 158, published August 17, 2015. The direct download (3.25 MB) can be accessed at https://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf.

- In the FY 2017 IPPS/LTCH Final Rule, CMS adopted one new claims-based outcome measure: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy. Additionally, an existing OCM, Radiation Dose Limits to Normal Tissues (National Quality Forum [NQF] #0382) was updated to expand the patient cohort to include patients receiving 3D conformal radiation for breast and rectal cancer. This applies to patients being treated in Calendar Year (CY) 2017 and applies to the FY 2019 program and subsequent years. Information for the PCHQR Program is contained on pages 57182–57193 in the *Federal Register*/Vol. 81, No. 162, published August 22, 2016. The direct download (3.43 MB) can be accessed at https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf.

- In the FY 2018 IPPS/LTCH PPS Final Rule, CMS finalized the removal of the three CST measures (NQF #0223, #0559, and #0220) beginning with diagnoses occurring as of January 1, 2018. Additionally, four new end-of-life (EOL) measures (NQF #0210, #0213, #0215, and #0216) were added to the program. These four claims-based measures will first be calculated from July 1, 2017, through June 30, 2018, and apply to the FY 2020 program and subsequent years. The information specific to the PCHQR Program is on pages 38411–38425 in the *Federal Register*/Vol 82, No. 155, published August 14, 2017. The direct download (7.64 MB) can be accessed at https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf.

- In the FY 2019 IPPS/LTCH PPS Final Rule, CMS adopted a new measure removal factor, Factor 8, to consider when evaluating potential measures for removal from the PCHQR Program measure set. Factor 8 states, "The costs associated with the measure outweigh the benefit of its continued use in the program." Four OCMs (NQF #0382, #0384, #0389, and #0390) were finalized for removal from the program for patients being treated in CY 2019. The removal applies to FY 2021 Program Year and subsequent years. Lastly, one new claims-based outcome measure, 30-Day Unplanned Readmissions for Cancer Patients (NQF #3188), was adopted. This measure also applies to FY 2021 Program Year and subsequent years. Information for the PCHQR Program is contained on pages 41609–41624 in the *Federal Register*, Vol. 83, No. 160, published August 17, 2018. The direct download (13.3 MB) can be accessed at https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf.

Section 2: Measures

The PCHQR Program has multiple types of measures that are collected and reported, starting with Program Year (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. Measures were adopted for PY 2013, with subsequent measures added for PYs 2014, 2015, 2016, 2017, 2018, 2019, 2020, and 2021. Refer to Appendix A for data submission dates.

Safety and Healthcare-Associated Infection (HAI)

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

Clinical Process/Oncology Care Measures (OCM)

- Oncology: Radiation Dose Limits to Normal Tissues (NQF #0382) (PCH-14)*
- Oncology: Plan of Care for Moderate to Severe Pain – Medical Oncology and Radiation Oncology (NQF #0383) (PCH-15)
- Oncology: Medical and Radiation – Pain Intensity Quantified – (NQF #0384) (PCH-16)*
- Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer (NQF #0390) (PCH-17)*
- Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (NQF #0389) (PCH-18)*
- Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (NQF #0210) (PCH-32)
- Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215) (PCH-34)

*NQF #0382, #0384, #0390, and #0389 were removed from the program beginning with patients treated as of January 1, 2019.

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) (NQF #0213) (PCH-33)
- Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216) (PCH-35)

Clinical Effectiveness Measure

- EBRT for Bone Metastases (PCH-25)

Patient Engagement/Experience of Care

- HCAHPS Survey (NQF #0166) (PCH-29)

Claims-Based Outcome Measures

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

- 30-Day Unplanned Readmissions for Cancer Patients (NQF #3188)

Measure Information

The sections below provide a summary of each measure set and the location of additional measure information. On electronic versions of this document, the blue measure numbers in the headings provide a direct link to the NQF website page for the specified measure. The NQF measure descriptions can be found at http://www.qualityforum.org/QPS.

Healthcare-Associated Infection (HAI)

For PY 2014, CMS initially adopted two HAI measures, CLABSI and CAUTI, from 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.

For 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, which are located on the NHSN website under the CMS Requirements link. 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 available at http://www.cdc.gov/nhsn/pdfs/cms/pchqr/pchqr-mrsa_op-guidance.pdf.

The 2019 NHSN Patient Safety Component Manual is posted on the NHSN website. The surveillance protocols and definitions contained within the 2018 manual should be used for surveillance and data collection beginning on January 1, 2018. 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.

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 beginning with 2013 data.

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. Note that for the purposes of the PCHQR Program, the CLABSI data that are sent by the CDC (via NHSN) to CMS do not have the Mucosal Barrier Infection-Laboratory-Confirmed Bloodstream Infections (MBI-LCBI) removed because there is not yet a predictive model for the PCHs that allows for the calculation of a standardized infection ratio (SIR). Please continue to monitor program communications for possible changes related to this issue.

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* Clostridium difficile *Infection (CDI) (PCH-26)*

CMS published final rules in the *Federal Register* on August 17, 2015, for the PCHQR Program that include a requirement for PCHs to 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 reporting requirement is for events that occur on or after January 1, 2016.

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 &* Clostridium 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)*

CMS published a final rule in the *Federal Register* on August 17, 2015, for the PCHQR Program. The final rules include a requirement for PCHs to 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 reporting requirement is for events that occur on or after January 1, 2016.

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 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.

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 is entered to ensure it is 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 no later than 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.

For HAI measures' reporting periods and submission deadlines, refer to Appendix A.

Additional Resources

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

Oncology Care Measures (OCM)

The OCMs, endorsed by the NQF, were initially derived from the Physician Quality Reporting System (PQRS) and are now part of the CMS Quality Payment Program (QPP). They assess the quality of medical assessment, treatment, and diagnostics of cancer by PCHs. The PCHs will collect and report aggregated numerators and denominators by quarter, with an annual submission period of July 1 through August 15.

CMS determined performances for NQF #0382, #0384, #0389, and #0390 were "topped out" and removed these measures from the program beginning with patients treated as of January 1, 2019 (i.e., the last treatment encounters to be reported as part of the PCHQR Program will be in August 2019 for patients treated in calendar year 2018 (Quarter 1 through Quarter 4 2018).

0382: Oncology: Radiation Dose Limits to Normal Tissues (PCH-14)

Identifying radiation dose limits to normal tissues is an important step in the process of care for patients receiving radiation therapy treatments. Although no specific data are available, in its practice accreditation reviews, the American College of Radiation Oncology has found that radiation dose limits to normal tissues are included in the patient chart less frequently than reviewers expected. While dose constraint specification is an integral part of Intensity Modulated Radiation therapy (IMRT), it is not required for 3D conformal radiation therapy. Patients treated with 3D conformal radiation therapy are often subjected to dose levels that exceed normal tissue

tolerance. Precise specifications of maximum doses to be received by normal tissues represent both an intellectual process for the physician during radiation treatment planning and a fail-safe point for the treating therapists. In most circumstances where facilities require specification of radiation dose limits to normal tissues prior to initiation of therapy, policies and procedures exist that prohibit exceeding those limits in the absence of written physician approval.

The numerator is defined as patients who had documentation in the medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs. The denominator includes all patients, regardless of age, with a diagnosis of pancreatic, lung, breast, or rectal cancer receiving 3D conformal radiation therapy. (Breast and rectal cancer diagnoses are added effective January 1, 2017.) Patients who have a diagnosis of metastatic disease are excluded from the denominator.

0384: *Oncology: Medical and Radiation - Pain Intensity Quantified (PCH-16)*

Pain, both acute and chronic, is one of the most frequently documented symptoms in the cancer patient population. Estimates on the prevalence of pain in this population vary depending upon a number of factors, such as type of assessment, treatment, extent of disease, type of cancer, and patient setting. Van den Beuken-van Everdingen and colleagues reported, in a meta-analysis, pain prevalence rates ranging from 33 percent in patients after curative treatment to 64 percent in patients characterized as having advanced/metastatic/terminal disease. Not only is pain a problem in its own right, but pain in the cancer patient has also been linked to decreased quality of life, depression, anxiety, and even decreased survival. The National Institute of Health's (NIH's) *Cancer Pain (PDQ®)–Health Professional Version* states, "Failure to properly assess pain is a critical factor leading to under-treatment."

Initial and ongoing pain assessments are essential to ensure proper pain management among patients with cancer. An inadequate assessment of pain is linked to poor pain control. Unrelieved pain has a significant impact on patients' quality of life, denying them comfort and greatly affecting their activities, motivation, and interactions with family and friends. Additionally, there is growing evidence that cancer survival is associated with effective pain management (NCCN, 2016).

The numerator is defined as the number of patient visits in which pain is assessed and documented as no pain present or, if pain is present, it is quantified using a standard instrument. The denominator includes all visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy. There are no exclusions.

0383: *Oncology: Plan of Care for Moderate to Severe Pain – Medical Oncology and Radiation Oncology (PCH-15)*

Once pain in a cancer patient is identified, it is imperative that, due to the physical, emotional, and quality of life implications, a plan of care for the pain is undertaken. The NIH has reported that up to 90 percent of cancer pain can be managed through relatively simple means. Others have cited research that proposes that 70–90 percent of cancer patients should be able to be effectively treated for their pain. Clinicians must respond to reported pain in a manner appropriate to the type of pain and setting. The National Comprehensive Cancer Network (NCCN) and others provide guidelines for opioids, non-opioid analgesics, and adjuvant analgesics. It should be noted that appropriate responses may not always include more opioids, but rather more detailed assessments, use of non-opioid analgesics or techniques, or non-pharmacologic interventions (e.g., education, relaxation, and use of heat or cold).

The numerator is defined as the number of patients for whom a plan of care to address moderate to severe pain is documented on or before the date of the second visit with a clinician. The denominator includes patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain. This measure was originally paired with NQF #0384. NQF #0384 was finalized for removal in the FY 2019 IPPS/LTCH PPS Final Rule.

0389: *Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (PCH-18)*

A bone scan is generally not required for staging prostate cancer in men with a low or very low risk of recurrence who are also receiving primary therapy. Low risk prostate cancer is defined as having all the following: a PSA of < 10ng/mL; AND a Gleason score of 6; AND clinical stage T1 to T2a. Very low risk prostate cancer is defined as having all of the following characteristics: a PSA < 10ng/mL; AND Gleason score of 6 or less; AND clinical stage T1c; AND presence of disease in fewer than 3 biopsy cores; AND ≤ 50% prostate cancer involvement in any core; AND PSA density < 0.15 ng/mL/g.

The numerator is defined as the number of patients who did not have a bone scan performed at any time since diagnosis of prostate cancer at the PCH. The denominator includes all patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence, receiving one of the following: interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy OR cryotherapy. Exclusions include medical and system reasons for having a bone scan performed.

0390: *Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer (PCH-17)*

If receiving EBRT as primary therapy, prostate cancer patients with a high or very high risk of recurrence should also be prescribed androgen deprivation therapy, which has been shown to increase the effectiveness of the radiotherapy and may also prolong survival. High risk prostate cancer is defined as having **one** of the following: a PSA > 20 ng/mL; OR a Gleason score of eight to ten/Gleason grade group 4–5; OR clinically localized stage T3a. Note that patients with multiple adverse factors may be shifted into the very high risk category. Very high risk of recurrence is defined as: clinical stage T3b to T4; OR primary Gleason pattern 5; OR more than four cores with Gleason score 8 to 10/Gleason grade group 4–5. This measure does not apply to those patients who receive EBRT to the prostate for salvage or adjuvant therapy. It is limited to those uses of EBRT as primary therapy in prostate cancer.

The numerator is defined as the number of patients who were prescribed androgen deprivation therapy in combination with external beam radiotherapy to the prostate. The denominator includes all patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving EBRT as primary therapy to the prostate. Patients who receive EBRT after prostatectomy (adjuvant radiation therapy) are not included in the measure. Exclusions include medical and patient reasons for not prescribing or administering androgen deprivation therapy in combination with external beam radiotherapy.

[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 such as 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 costs, increased hospitalizations, and a reduced quality of life. 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 patients, which evaluates the proportion of patients 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, NQF #0216 (below).

This is a claims-based process measure which includes all Medicare beneficiaries at the PCH. The denominator for this measure is defined as all Medicare beneficiaries 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.

OCM Reporting Period and Submission Deadlines

For the OCMs NQF #0382, #0383, #0384, #0389, and #0390 reporting period and submission deadlines, refer to Appendix A. The end-of-life OCMs (NQF #0210 and #0215) are claims-based measures and, as such, no data submission is required by the program participants. The CMS analytics contractor will calculate these performance rates based upon Medicare administrative claims data and report them to CMS on behalf of the PCHs.

Intermediate Clinical Outcome Measures

[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 NQF #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. NQF #0213 is a claims-based intermediate clinical outcome measure that uses Medicare billing data. The measure denominator is defined as the Medicare 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-34)

The potential impact of hospice care on quality of life and cost is outlined in the discussion of NQF #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" (FY 2018 IPPS/LTCH PPS Final Rule, pg. 38419) and overall improvement in the quality of care for cancer patients at the end of life.

This measure, closely related to NQF #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 beneficiaries within PCHs. The denominator consists of those 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.

Intermediate Clinical Outcome Measures Reporting Period and Submission Deadlines

The end-of-life intermediate clinical outcome measures (NQF #0213 and #0216) are claims-based measures, and no data submission is required by the program participants. The CMS analytics contractor will calculate these performance rates based upon Medicare administrative claims data and report them to CMS on behalf of the PCHs.

Additional Resources

- For detailed measure specifications regarding the OCM and intermediate clinical outcome measures, refer to the materials located in the zip file entitled "*Quality Measure Specifications*" located at the [2019 Quality Payment Program Resource Library.](#) As further measure specifications for the claims-based measures (NQF #0210, #0213, #0215, and #0216) become available, this information will be disseminated to the program participants.

- For an overview of the topic of palliative and end-of-life care, participants may refer to the NQF publication [Palliative and End-of-Life Care 2015-2016.](#)

Clinical Effectiveness

The PCHQR Program supports the National Quality Strategy (NQS) national priorities, the Department of Health & Human Services (HHS) Strategic Plans and initiatives, and the CMS Quality Strategy, and strives to reduce the burden on participating PCHs whenever possible. In alignment with this mission, the following measure was added in FY 2015 to reduce the rate of EBRT services, decrease overuse, promote patient safety, and support the priority of palliative care for cancer patients.

N/A: External Beam Radiotherapy for Bone Metastases (EBRT) (PCH-25)

The EBRT measure was developed to assess radiation therapy in the management of painful bone metastases. Bone metastasis is a common manifestation of malignancy and the evidence review shows variation in treatment with EBRT.

The role of radiation therapy in palliation of bone metastases has been well established; however, literature shows widespread variation in the practice patterns for using radiation therapy for palliation. The measure reports the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who received EBRT with an acceptable fractionation scheme, as defined by the guideline.

The numerator is defined as the number of patients who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns; 24Gy/6fxns; 20Gy/5fxns; or 8Gy/1fxn. The denominator includes all patients with a diagnosis of bone metastases who have an order for EBRT to treat a metastatic bone lesion. Exclusions from the denominator include previous radiation to the same anatomic site; treatment with stereotactic body radiation therapy (SBRT) or stereotactic radiosurgery (SRS); enrollment in a clinical trial or registry study involving the use of radiation therapy; femoral axis cortical involvement >3 cm in length; previous surgical stabilization of the site; spinal cord or cauda equina compression or radicular pain; and patient specific exclusions. The patient-specific exclusions are limited to patient declination of therapy or economic, social, or religious reasons.

EBRT Measure Reporting Period and Submission Deadlines

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

Additional Resources

For detailed information regarding this measure, refer to the [EBRT measure specifications](#).

Sampling (NQF #0382, #0383, #0384, #0389, # 0390, and PCH-25)

The sampling methodology allows for different numbers of cases to be reported based on each PCH's cancer patient population size. Sampling should be systematic to ensure that all eligible cases have an equal chance of inclusion. PCHs must submit aggregate data for the required quarters during the data submission period.

Average Quarterly Initial Population Size "N"	Minimum Required Sample Size "N"
>125	25 cases
51–125	20 percent of the Initial Patient Population
10–50	10 cases
<10	No sampling; 100 percent of the Initial Patient Population

There has been extensive discussion between the PCHQR Program participants, the measure stewards, CMS, and the Support Contractor (SC) about the sampling for the OCM measures NQF #0383 and #0384. The numerator patients identified in NQF #0384 (those who have pain and the pain intensity is quantified) are the denominator patients for NQF #0383. To obtain a larger, more representative sample size for NQF #0383, many participants choose to "over sample" for NQF #0384. Remember that the sample sizes in the above table are a minimum sample size. Participants are asked to refer to the PCHQR Program webinar of September 24, 2015, for an in-depth review of this topic: *NQF #0384 and #0383 Sampling, Assessment, and Lessons Learned*.

NQF measures #0210, #0213, #0215, and #0216 are claims-based measures and, therefore, there is no sampling provision.

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 HCAHPS Survey produces 11 reported measures. Seven measures are multi-item measures, including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information, and how well patients understood the care they would need after leaving the hospital. Four measures are single-item measures, including: cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of the hospital.

Sampling

The HCAHPS specifications describe a precise method for sampling, with patients surveyed throughout each month of the year. PCHs must achieve at least 300 completed surveys over four calendar quarters.

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 regarding the HCAHPS measures, refer to the specifications located at http://www.hcahpsonline.org/en/technical-specifications/.

Claims-Based Outcome Measures

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

Admission and Emergency Department (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://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

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 guidelines from the ASCO, NCNN, Oncology Nursing Society, Infectious Diseases Society of America, and other professional societies 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 fee-for-service (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 patients 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 all 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.

[3188](): 30-Day Unplanned Readmissions for Cancer Patients

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 Fee-for-Service 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 Prospective Payment (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 Fee-for-Service 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.

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 on *Hospital Compare*.

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 the 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 reference periods for the other measures denote designated measure periods (diagnosis cohort, patient visit, inpatient discharge dates, etc.).

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	Via the CDC NHSN
Clinical Process/Oncology Care • Oncology: Radiation Dose Limits to Normal Tissues* • Oncology: Plan of Care for Moderate to Severe Pain • Oncology: Pain Intensity Quantified • Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer* • Prostate Cancer: Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients*	Data entered annually, stratified by quarter, via WBDCT within the *QualityNet Secure Portal*. ***NOTE:** The last treatment encounters to be reported as part of the PCHQR Program will be in August 2019 for patients treated in calendar year 2018 (Quarter 1 through Quarter 4 2018).
Clinical Process/Oncology Care • Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life • Proportion of Patients Who Died from Cancer Not Admitted to Hospice	These measures are collected by CMS through claims data. There is no action required by facilities to collect and submit data for this measure.

Measure Topic/Names	Method of Reporting
Intermediate Clinical Outcome 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 Admitted to Hospice for Less Than Three Days	These measures are collected by CMS through claims data. There is no action required by facilities to collect and submit data for this measure.
Clinical Effectiveness • EBRT for Bone Metastases	Data entered annually, stratified by quarter, via WBDCT within the *QualityNet Secure Portal*.
Patient Engagement/Experience of Care • HCAHPS	Submitted via vendor or uploaded via the *QualityNet Secure Portal* using the online data entry tool or in XML format.
Claims-Based Outcome Measure • Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy • 30-Day Unplanned Readmissions for Cancer Patients	These measures are collected by CMS through claims data. There is no action required by facilities to collect and submit data for this measure.

Note that specific instructions for submitting measures using the WBDCT within the *QualityNet Secure Portal* may be found in the March and June 2017, PCHQR Program Educational Events page of *QualityReportCenter.com*.

Extraordinary Circumstances

A facility can request an extension or waiver of various quality reporting program requirements due to extraordinary circumstances beyond the control of the facility. To request an exemption, complete and submit the Extraordinary Circumstances Exceptions (ECE) Request Form located on the PCHQR Program Resources tab of *QualityNet* 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 meaningful for *Hospital Compare* or sufficiently reliable to be utilized 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 is 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 Data Submission page.

Section 4: *QualityNet* Registration Process

To participate and submit data for reporting in the PCHQR Program, facilities must obtain a *QualityNet* user account and register for access to the *QualityNet Secure Portal.* More information regarding this process can be found on the PCHQR Program *QualityNet* Registration page.

All users requesting access to the *QualityNet Secure Portal* must be individually approved and verified at the facility level and submitted to *QualityNet*. This mandatory registration process is used to maintain the confidentiality and security of healthcare information and data transmitted via the *QualityNet Secure Portal.* These are CMS-approved sites for secure healthcare quality data exchange to enable facility reporting.

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 with *QualityNet* and enroll in the *QualityNet Secure Portal.*
2. Maintain an active *Security Administrator.*
3. Have a *Notice of Participation.*
4. Submit data based on the data collection and submission timelines.
5. Complete the Data Accuracy and Completeness Acknowledgement (DACA) by the submission deadline.

Security Administrator/Non-Administrative User Registration Process

To begin the registration process:

1. Navigate to the *QualityNet* website located at http://www.qualitynet.org.

   The *QualityNet* home screen appears.

2. On the left-hand side of the home screen, under the section labeled *QualityNet Registration*, select the **Cancer Hospitals** link.

The *QualityNet* Registration: PPS-Exempt Hospital Quality Reporting (PCHQR) Program screen appears.

3. Select the **Security Administrator** or **Basic User** link, depending on the type of user to be registered.

4. To access the *QualityNet* Security Administrator Registration Packet, select **Security Administrator** from the *QualityNet* Registration: PPS-Exempt Hospital Quality Reporting (PCHQR) Program screen.

The *QualityNet* Security Administrator Registration screen appears.

Select the **QualityNet Security Administrator Registration Packet** link located in the first sentence of the first step. After downloading the packet, follow the instructions for completing and submitting the registration and authorization forms.

5. To access the Basic User Registration Packet, select **Basic User** from the *QualityNet* Registration: PPS-Exempt Hospital Quality Reporting (PCHQR) Program screen. Then, select **New User Enrollment Process** and follow the enrollment, first-time login instructions.

QualityNet Security Administrator

The PCHQR Program requires every facility to have at least one active *QualityNet* Security Administrator (SA). It is strongly recommended that facilities designate a minimum of two *QualityNet* SAs, one to serve as the primary *QualityNet* SA and the other to serve as the alternate SA. To keep your facility's account active, your SA should sign in to the *Secure Portal* 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* Help Desk at (866) 288-8912.

Security Administrator Responsibilities

The PCH SA has the following responsibilities:

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

Non-Administrative User

Any user not designated as a *QualityNet* SA 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

Completing the QualityNet Registration Form

When completing the *QualityNet* Registration Form, print the information legibly and completely in each of the applicable fields. Then, follow the steps below.

QualityNet Security Administrator Registration Form			
*Note: All fields marked with an asterisk are required and must be completed to obtain approval.			
Access Request			
***Request Date:**	***First Name:**	**Middle Initial:**	***Last Name:**
***Business Email Address:**			
***Job Title:**			
***Business Name:**			
***Specify Setting:** *(check all that apply)*			

☐ ASC ☐ ESRD Network ☐ Hospital – Inpatient ☐ Inpatient Psychiatric Facility
☐ CMS ☐ Healthcare System ☐ Hospital – Outpatient ☐ Long-Term Care Facility
☐ EHR ☐ Long-Term Care Facility ☐ Physician Office ☐ PPS-Exempt Cancer Hospital
☐ BFCC QIO ☐ QIN QIO ☐ State Agency
☐ Vendor: ASC ☐ Vendor: EHR ☐ Vendor: Hospital-HCAHPS
☐ Vendor: Hospital – Inpatient ☐ Hospital – Outpatient ☐ Vendor – Inpatient Psychiatric Facility
☐ Other (Specify): _____

1. Select the **PPS-Exempt Cancer Hospital** box, in the *Specify Setting* section.

2. Sign and date the *QualityNet* Security Administrator Form. Currently, for *QualityNet* account registration, the SA forms do not need to be notarized. However, the Basic User forms need to be notarized, signed, and dated in the presence of a Notary Public with the Notary's stamp and seal on the form.

3. Have the highest-level executive at your location complete and sign the *QualityNet* Security Administrator Authorization Form. Depending on the facility, this may be the Chief Executive Officer, Administrator, Medical Director, or other similar position.

4. Mail the forms as instructed in the packet. This will initiate a process whereby the applicant will receive a user ID via a welcome email. The *QualityNet* SA who created the account should provide a temporary password. If the account was processed by the *QualityNet* Help Desk, a temporary password will be sent immediately after the welcome email containing the user ID.

   Refer to the information below for mailing instructions of the original, completed *QualityNet* Security Administrator Registration Form and the *QualityNet* Security Administrator Authorization Form.

   NOTE: Photocopies or faxes of the forms will not be accepted. The facility should retain a copy of all forms for its records.

   Mail the original completed form (not a copy) to the *QualityNet* Help Desk at:

   > *QualityNet* Help Desk
   > 12000 Ridgemont Drive
   > Urbandale, IA 50323-2317

   For questions regarding the QualityNet *Registration Form*, contact:

   > *QualityNet* Help Desk
   > Monday through Friday
   > 7 a.m. to 7 p.m. CT
   > E-mail: qnetsupport@hcqis.org
   > Phone: (866) 288-8912
   > TTY: (877) 715-6222
   > FAX: (888) 329-7377

Activating Security Administrator Account When Email Notification Received

Once the *QualityNet* registration forms are processed by *QualityNet*, the approved SA(s) will receive an email notification with the individually assigned username. The *QualityNet* SA who created the account should provide a temporary password. If the account was processed by the *QualityNet* Help Desk, a temporary password will be sent immediately after the welcome email containing the user ID.

To begin account activation:

1. Go to the QualityNet.org website.

2. Select the **Log In** button or **Login** link.

3. Enter the assigned username and temporary password provided via the email notification.

4. Follow the instructions to establish a new password.

   After the password is established, the user must complete the enrollment to obtain access to the *QualityNet Secure Portal*. This establishes access to the web-based Notice of Participation (NOP), web-based measures, DACA applications, and PCHQR Program reports.

QualityNet Secure Portal Access

Before logging in to the *QualityNet Secure Portal* for the first time, a user must complete the **New User Enrollment Process**. The prerequisites for this process are the following:

- A completed *QualityNet* Registration
- Receipt of the applicable user roles assigned by your facility's SA
- A completed Symantec VIP multifactor credential application in order to obtain VeriSign, an authentication service that enables secure access to networks and applications

To download the multifactor authentication application to a PC or tablet:

1. Go to the QualityNet.org website. Select the **Download Symantec ID** link.

2. The VeriSign ID Protection Center* page will appear.

*The VeriSign ID Protection Center website is also available at: https://idprotect.vip.symantec.com/mainmenu.v.

3. Select the download option that is appropriate to the device, either Windows® or Mac®.

   NOTE: It may be necessary to consult with your IT department before downloading the VeriSign ID to the PC due to system firewalls or other restrictions.

   Once the Symantec multifactor authentication application download is on the computer, users are ready to access the *QualityNet Secure Portal.*

4. Access the *QualityNet Secure Portal* from the QualityNet.org website and then select the **Log In** button or **Login** link. The Log In to *QualityNet* window appears.

Each PCHQR Program user must complete the authenticating (proofing) process, required by the Federal Information Security Management Act (FISMA), for accessing government systems.

5. Select the **Start/Complete New User Enrollment** link on the login page to begin the enrollment process. The *QualityNet Starting and Completing New User Enrollment* page appears.

6. Enter your **User ID** and **Password** and select **Submit**.

7. Follow the instructions for the enrollment process described in the following sections.

Verifying Identity

To verify a user's identity:

1. Access the *QualityNet Starting and Completing New User Enrollment* page and log in. The *Verify Your Identity* page appears.

2. Enter the required information within each field on the screen.

   A Social Security number is required for users residing within the United States. A Social Security number is considered the most available source of identification that can be verified, as not all users have a driver's license or passport. When a user enters a Social Security number, the screen displays hash marks instead of numbers to protect privacy.

   NOTE: You must enter your personal street address, NOT your associated facility's address.

   CMS is aware of the privacy concerns regarding disclosure of personal data, including social security numbers. CMS is collecting the Personally Identifiable Information (PII) on this screen and on the identity question screen to verify identity only. Verifying a user's identity meets the National Institute of Standards and Technology (NIST) and the FISMA requirements.

   FISMA was passed as Title III of the E-Government Act (Public Law 107-347) in December 2002. FISMA requires each federal agency to develop, document, and

implement an agency-wide program to provide information security for the information and information systems that support the operations and assets of the agency, including those provided or managed by another agency, contractor, or other source. This act assigned NIST the responsibility to develop standards to be used by federal agencies to categorize information and information systems based on the objectives of providing appropriate levels of information security according to a range of risk levels.

CMS is complying with the NIST standards by verifying a user's identity using Experian's Precise ID platform (an external authentication service provider). To maintain the privacy of users, Social Security numbers will be masked and encrypted during this transaction to ensure they are secure. Other than a name, none of the PII data collected in this process is retained by CMS.

3. Once the required fields have been entered, check the privacy statement. Click **Submit**.

The screen will display a message stating that the information has been sent to Experian and instructing the user to wait as the information is being processed.

A set of Identity Challenge Questions will be generated for you to answer.

Example questions may be downloaded from the User Guide located on *QualityNet*. Typical types of identity proofing questions include:

- Verification of where you live or have lived (street address, city, and state)
- Verification of the type of car you own or leased (color, make, license plate number)
- Verification of banking institutions that you may have used for banking or various types of loans
- Verification of phone numbers (home and cell)
- Verification of education completed
- Verification of where you have been employed
- Verification of dates associated with any of the above activities

4. Answer the identity proofing questions, and then select **Submit**.

Once a user has completed the identity proofing questions correctly, the verification will display on the screen indicating successful completion of CMS Identity Proofing.

If the questions are not answered accurately or if there is an alert on the credit report due to identity theft, the user will be prompted to call Experian to complete telephone verification.

A phone number will appear on the screen. If unsuccessful during the telephone verification, the user will be referred to the facility's SA to complete face-to-face verification.

NOTE: An individual user must have attempted both the online and telephone verification before a face-to-face verification can be done.

Enrolling the Credentials

To enroll credentials, access the *QualityNet Starting and Completing New User Enrollment* page. After entering identity questions, the next step is to **Enroll Your Credential**.

Steps for enrolling the two-factor credential are as follows:

1. Access the previously downloaded Symantec VIP Application from your desktop. The Symantec VIP window appears.

2. Enter the Credential ID number in the first field.

3. Enter the Security Code within the 30-second freshness period.

    NOTE: A counter will count down the seconds from 30 until the next code displays. The security code may be typed in the field or copied and pasted into the Security Code field.

4. Select **Submit**.
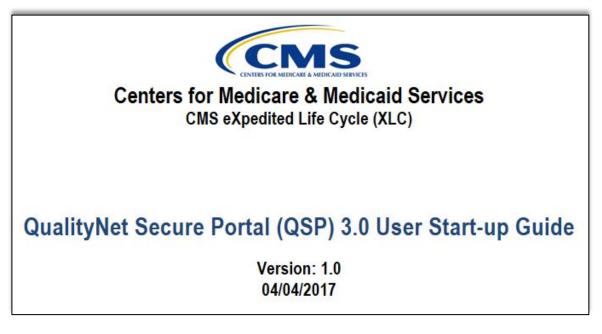
For additional information on the New User Enrollment Process, select the *QualityNet* **Secure Portal User Start-Up Guide** link at:
https://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228773343598.

The link is found under Resources in the *QualityNet* website.

The New User Enrollment Process information is contained in the **Getting Started > Accessing the System** section of the guide.

Logging In to the QualityNet Secure Portal

After completing all necessary paperwork and the New User Enrollment, a user will have access to the *QualityNet Secure Portal*.

To access the *QualityNet Secure Portal*:

1. Go to the QualityNet.org website and select the **Log In** button or **Login** link.

2. The *Choose Your QualityNet Destination* screen appears. Select **PPS-Exempt Cancer Hospital Quality Reporting Program**.

3. The *Log In to QualityNet* screen appears. Enter the **User ID**, **Password**, and **Security Code*** and then select **Submit**.

*Retrieve Security code (time sensitive): Open the Symantec VIP application. Copy the VIP security code and paste the VIP security code in the Security Code box.

For additional information on the login process, refer to the QualityNet Secure Portal *User Start-Up Guide*.

4. The security screen will be displayed, indicating the user has accessed a U.S. Government Information system.

5. Accept the terms to be granted access to the *QualityNet Secure Portal*.

6. The Quality Reporting *Secure Portal* page appears. To access the PCHQR Program, click on the drop-down arrow next to Quality Program; then select **Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR**.

After selecting the Quality Program, the My Tasks page is displayed on the next screen.

The content of the My Tasks page is dependent upon the user roles assigned to the individual. 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

User Roles

For the PCHQR Program, there are only two types of user designations for any of the authorized roles 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 roles 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 Authorization

- PCH Vendor Authorization

File Exchange

- File Search and Exchange

Online Access Request System (OARS)

- OARS Approve Users
- OARS Create/Edit Users
- OARS Final Approval

Manage Security Settings

After gaining access to the *QualityNet Secure Portal,* users can manage their account information on the **My Tasks** 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 Account Information

To update your account information:

1. On the **Quality Reporting System: My Tasks** page under **Manage Security**, select **My Account**.

2. The **My Account** window will open. Scroll down to review current entries. The fields will be pre-populated with the information that you provided in the initial account setup. Update the contact information as needed and then select the **Submit** button to save your changes.

Password Reset/Change

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

1. On the *Quality Reporting System: My Tasks* page under *Manage Security*, select **My Account**.

Manage Security
Manage Multifactor Credentials
My Account

2. The *My Account* screen will appear. Select the **Change your password** link to reset/change the password.

My Account

* Indicates required fields.

Password

Your password will expire on May 14, 2018.
Change your password >
Update your security questions >

3. The *Account Security* window will open. Complete all fields and then select the **Submit** button to change the password.

   NOTE: Review password rules before changing your password. Rules are located on the Account Security page as shown below.

Account Security

Change Password

Old Password

New Password

Confirm New Password

Passwords *must* have:
- 8 to 16 characters
- an upper-case letter, a lower-case letter, and a digit
- a letter as the first character
- at least one of the following % # * + - , : = ? _
- no other special characters
- no embedded account values (first name, last name, email, etc...)

View All Password Rules >

Cancel Submit

Update Security Questions

To update your security questions:

1. On the *Quality Reporting System: My Tasks* page under *Manage Security*, select **My Account**.

Manage Security
Manage Multifactor Credentials
My Account ←

2. The *My Account* screen will appear. Select **Update your security questions**.

3. The *Account Security* window will open. The security question fields will be pre-populated with the information that was provided in the initial account setup.

Review and/or update the answers to the questions. Answer at least six questions. You are not required to answer all 10 questions.

Account Security

Security Questions

You must answer at least 6 of the following:

What city were you born in?	
What is your favorite movie?	
What is your favorite season of the year?	
What is your favorite sport?	
What is your mother's maiden name?	
What size shoe do you wear?	
What was the color of your first car?	
What was the make of your first car?	
What was the name of your first pet?	
What year did you graduate from high school?	

Cancel **Submit**

4. Select the **Submit** button to save your changes.

Section 5: Vendor Authorization

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.

To receive the vendor registration instructions and forms, the vendor may submit an email request to one of the following email addresses: vendorreg@hcqis.org or qnetsupport@hcqis.org.

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.

Currently, vendor authorization is required only for submission of the quarterly HCAHPS data for the PCHQR Program.

Vendors must be authorized to submit data on behalf of providers. The **Authorize Vendors to Submit Data** option enables providers to authorize vendors to submit web-based measure information. It also enables providers to update existing authorizations.

PCHs must have the PCH vendor authorization role to access the **Vendor Authorization** link.

1. From the Quality Programs tab on the *QualityNet Secure Portal* landing page, select the **Quality Programs: Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR** link. The *Quality Reporting System: My Tasks* page appears.

2. Choose the **Vendor Authorization** link. The *Vendor Authorization* screen appears.

Provider Information

Provider	CCN	NPI

To authorize and add a new vendor to the list, click the 'Add New Vendor Authorization' tab. Then select the Vendor and, for the measure set(s) of interest, enter the required Start Discharge Date and the required Start Data Transmission Date. Entering End dates for both will put a time limit on the authorization, which will end after the End Dates.
To update a currently authorized vendor, click the 'Update Vendor Authorization' tab. Select the Vendor and the measure set(s) of interest. Then add or modify the dates of interest.

I'd Like To
Add New Vendor Authorization
Update Vendor Authorization
View Previous Authorizations
Select Another HQR Program

3.   Select a program from the HQR Program drop-down list and click **Submit**. The *Authorize Vendor to Submit Data* screen appears.

4.   Select either the **Add New Vendor Authorization** or the **Update Vendor Authorization** link.

All vendors that have been allowed to submit clinical data on the institution's behalf are automatically authorized to submit web-based measures for the data submission period beginning July 1, 2014.

5.   Select a vendor from the list and verify the correct vendor is displayed.

NOTE: Use the **Cancel** button to return to the previous page to make a vendor change, if necessary.

6.   Scroll to the measure.

7.   Select the **Calendar** icon to choose a **Discharge/Encounter Date > Start** and **Data Transmission Date > Start** for the measures.

Both start dates are required, but end dates are not. **Discharge/Encounter Date > Start Date** must be the first day of a quarter. The **Data Transmission Date > Start Date** must be equal to or greater than the current date.

Recommendations

Do not enter end dates unless it is known that a specific vendor will not submit data after the specified end dates or if you are converting from one CMS Certification Number (CCN) to a new CCN. The **Discharge/Encounter Date > End Date** must be the last day of a quarter.

If you are terminating a vendor relationship at the end of a submission period, it is recommended that you do not enter the submission deadline date as the **Data Transmission Date > End Date** due to the possibility of a submission date extension. It is recommended that you enter the **Data Transmission Date > End Date** when all data have been transmitted.

If more than one vendor is authorized for the same topic and timeframe, a message indicating there is more than one vendor authorized to submit data for the same measure set and time period will display. You will be able to proceed, but you will need to verify that the dates entered are correct.

8. Decide if the vendor selections are correct.

   - Select **Cancel** to return to the vendor's currently authorized page without saving.
   - Select **Continue** to proceed.

   The **Approve New or Changed Vendor Authorization** page appears.

9. Verify that the vendor information and authorized dates are correct.

   - Select **Submit** if the information is as desired.
   - Select **Edit** to return to the previous page to make any date changes.

   NOTE: Once an authorization has been submitted, future dates are the only dates that can be modified. If incorrect dates were entered and need to be modified, please send an email to qnetsupport@hcqis.org or call (866) 288-8912.

   The **Vendor Authorization Complete** page will display and summarize the submitted Vendor Authorization.

10. Select **Print** for a printer-friendly copy of the authorization.

Section 6: Notice of Participation (NOP)

The PCHs electing to participate in the PCHQR Program must complete a Notice of Participation (NOP) via the *QualityNet Secure Portal*. 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 *Quality Reporting System: My Tasks* page.

NOTE: Hospitals with a PCHQR Program NOP will remain active program participants until a withdrawal is submitted via the *QualityNet Secure Portal*.

Accessing the Online NOP Application

To access the NOP application:

1. Ensure the PCHQR Program NOP Read or PCHQR Program NOP Update (to add or edit) role has been assigned by the SA.

2. Access the *View/Edit Notice of Participation* screen.

   Users that are affiliated with only one facility will see their facility's six-digit CCN after selecting the **Manage Notice of Participation** link under the *My Tasks* screen.

   Users that are affiliated with more than one facility will be prompted to enter the six-digit CCN as shown below.

3. Select the action to be completed: **View**, **Add**, or **Update** the Notice of Participation, Facility Contacts, or Additional Campus information. Additional campus information may not apply to all PCHs. It is applicable for facilities that have more than one physical location but are licensed and reimbursed under the same CCN.

Quality data are reported and published under the same CCN regardless of the number of physical locations associated with a CCN.

4. Enter the contact information if this is the first time the NOP is being added.

5. Select **Contacts** from the list.

    Enter at least <u>two</u> facility contacts within the contact screen. The contact information is used for sending email alert notifications if edits are made within the NOP application.

6. If the facility completed a paper NOP, then there will not be any contact information entered in the application. It is recommended that the facility log in and update the contact information.

7. Select the desired pledge option and the acknowledgement check box.

    Upon initial completion of the NOP, two pledge options are available: **Participate** or **Do not agree to participate**.

PCHQRP Notice of Participation | Text

Provider Name

PPS-Exempt Cancer Hospital

Provider ID

999999

Medicare Accept Date

Facility Close Date

PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program Notice of Participation

Please review the Notice of Participation below.

PPS-exempt Cancer Hospital Quality Reporting Program Notice of Participation (Pledge Form) - Agreement

The hospital agrees to follow procedures for participating in the PCHQR Program as outlined in the federal regulations found in the Federal Register, or is indicating its decision to decline participation.

Each hospital must complete this "PCHQR Notice of Participation" as outlined in the Federal Register. In an effort to alleviate the burden associated with submitting this form annually, effective with the PCHQR Notice submitted for participation in FY 2014 or later, a hospital that indicated its intent to participate will be considered an active PCHQR participant until CMS determines a need to pledge again, or the hospital submits a withdrawal to CMS.

This information is in compliance with the CMS guidelines for hospitals submitting their quality performance data in accordance with Section 5001(b) of the Deficit Reduction Act of 2005. Hospitals must also continue to display quality information for public viewing as required by section 1866(k)(4) of the Social Security Act. Before this information is displayed, hospitals will be permitted to review their information as it is recorded. Eligible hospitals must follow the regulations as outlined in the federal regulations.

* We entities operating under the submitted Provider ID:500138
  ○   Agree to participate.
  ○   Do not agree to participate.
  ○   Request to be withdrawn from participation.

This acknowledgement (to participate or not to participate or to withdraw) remains in effect until an electronically signed acknowledgement applying changes has been entered.

*   ☐   By entering my acknowledgement, I hereby issue this PCHQR Notice of Participation with the specified direction contained within:

By entering this pledge, I agree to:

- (1) Transmit or have data transmitted to CMS; and
- (2) Permit my hospital's performance information to be publicly reported.

CANCEL   SAVE

8. Following the pledge selection, select the **Save** button.

A confirmation screen appears asking the user to confirm the selection in order to save the document.

Once a facility has agreed to participate, they remain a program participant until they log in and select the **Request to be withdrawn from participation** option.

Detailed information about the NOP application is accessible on the *QualityNet* Home page by logging in through the *QualityNet Secure Portal* at http://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetHomepage&cid=1120143435363.

Section 7: Data Accuracy and Completeness Acknowledgement (DACA)

Beginning with PY 2015, PCHs should complete an online Data Accuracy and Completeness Acknowledgement (DACA) to attest to the accuracy and completeness of the entered data.

The DACA must be completed annually by the August 31 submission deadline, prior to the respective PCHQR Program Year (e.g., for Program Year 2019, the DACA should be completed by August 31, 2018). The DACA web application is accessible annually between July 1 and August 31, as shown in the example below:

1. On the next screen select **PPS-Exempt Cancer Hospitals DACA**.

2. Choose the appropriate Fiscal Year from the drop-down list and select **Continue**.

The Summary screen will display the status of the DACA submission as **Incomplete**

or **Complete**.

3. Select the blue **DACA** hyperlink to begin the DACA submission process, if the DACA status is Incomplete.

4. Select the **Yes, I Acknowledge** checkbox and complete the **Position** field.

5. Click the **Submit** button to complete the DACA submission.

    NOTE: The **Submit** button opens an editable DACA screen.

6. Select the **Print** button to print the completed DACA.

7. Select the **Return to Summary** button to return to the previous screen.

PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program

Data Accuracy and Completeness Acknowledgement

To the best of my knowledge, at the time of submission, all of the information reported for this hospital for the PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program, as required for the annual Fiscal Year 2019 PCHQR Program requirements, is accurate and complete. This information includes the following:

- *Measure sets as defined for the PCHQR Program;*
- *All program requirements (e.g., where applicable, chart abstraction, validation and sampling) as defined for the PCHQR Program); and*
- *Current Notice of Participation and QualityNet Security Administrator.*

I understand this acknowledgement covers all PCHQR information reported by this hospital (and any data or survey vendor(s) acting as agents on behalf of this hospital) to the Centers for Medicare & Medicaid Services (CMS) and its contractors for the FY 2019 .

To the best of my knowledge, at the time of submission, this information was collected in accordance with all applicable requirements. I understand that this information is used as the basis for the public reporting of quality of care and patient assessment of care.

I understand that this acknowledgement is required for purposes of meeting any Fiscal Year 2019 PCHQR Program requirements.

Acknowledgement has been submitted by:
Name   **Position**   **Date**   **Time**

Once the DACA is submitted, the Summary screen displays a **Completed** status.

Start Structural/Web-Based Measures

PPS Exempt Cancer Hospitals DACA

Submission Period   **With Respect to Reporting Period**
07/01/2018 - 08/31/2018   09/01/2017 - 08/31/2018

Structural Measures | FY

Provider ID	DACA
999999	Completed

8. To view the completed DACA, select the blue **DACA** hyperlink.

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 Facility Report

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

To run a PCHQR Facility Report:

1. Select **Run Reports** from the *My Reports* drop-down menu in the yellow tool bar near the top of the summary screen.

2. Select the **Run Report(s)** tab.

3. Choose **PCHQR** for Report Program and **PPS-Exempt Cancer Hospital – Feedback Reports** for Report Category. Then, select the **View Reports** button.

4. Select the **PPS-Exempt Cancer Hospital Report**.

5. Enter your desired report parameters, and select the **Fiscal Year** from the drop-down list, e.g., **2018**.

6. Select the **Run Report** button.

7. Select the **Search Reports** tab.

8. Select the new report and open it.

Hospital Reporting – PPS-Exempt Cancer Hospital Report		
Provider Name: **PPS-Exempt Cancer Hospital**		
CCN: **999999**		
Fiscal Year: **2018**		
Exception Form on File: **NO**		
Measure Set: Safety and Healthcare-Associated Infection—HAI		**Measure: CLABSI**
Oncology Location Type	**Numerator**	**Denominator**
Discharge Quarter: 01/01/2017 - 03/31/2017		**Last NHSN Update: 09/18/2017**
General Hematology/Oncology Ward	10	4186
Pediatric General Hematology/Oncology Ward	5	1311
Medical-Surgical Critical Care	2	1215
Hematopoietic Stem Cell Transplant Ward	40	7452
Discharge Quarter: 04/01/2017 - 06/30/2017		**Last NHSN Update: 11/16/2017**
General Hematology/Oncology Ward	7	4052
Pediatric General Hematology/Oncology Ward	5	1277
Medical-Surgical Critical Care	1	993
Hematopoietic Stem Cell Transplant Ward	29	7374
Discharge Quarter: 07/01/2017 - 09/30/2017		**Last NHSN Update: 02/16/2018**
General Hematology/Oncology Ward	8	3961
Pediatric General Hematology/Oncology Ward	13	1302
Medical-Surgical Critical Care	4	923
Hematopoietic Stem Cell Transplant Ward	31	7223
Discharge Quarter: 10/01/2017 - 12/31/2017		**Last NHSN Update: 03/16/2018**
General Hematology/Oncology Ward	10	4250
Pediatric General Hematology/Oncology Ward	7	1265
Medical-Surgical Critical Care	2	961
Hematopoietic Stem Cell Transplant Ward	30	7237
Last NHSN Update is the date of the most recently updated HAI Measure Data for the discharge quarter from the Centers for Disease Control (CDC).		

PCHQR Program HCAHPS Report

The *QualityNet Secure Portal* also displays HCAHPS data for the PCHQR Program participants, starting with the first PCHQR Program HCAHPS data submission in October 2014.

The PCHQR Program HCAHPS reports are accessed through the Hospital IQR Program selection.

To run a PCHQR Program HCAHPS Report:

1. Select **Run Reports** from the **My Reports** drop-down menu in the yellow tool bar near the top of the summary screen.

2. Select the **Run Report(s)** tab.

3. Select **IQR** for **Report Program** and **HCAHPS Warehouse Feedback Reports** for **Report** Category. Select the **VIEW REPORTS** button.

4. Select the **HCAHPS Data Review and Correction Report**.

5. Enter your desired report parameters. Select the **Discharge Quarter** from the drop-down list.

6. Select the **Run Report** button.

7. Select the **Search Reports** tab.

8. Select the new report and open it.

HCAHPS Data Review and Correction Report
Provider: 999999
Discharge Quarter:10/01/2017 - 12/31/2017

Provider ID: 999999	Provider Name:PPS-Exempt Cancer Hospital
NPI	
Discharge Year	2017
Discharge Month	10
Data As Of[1]	03/20/2018 03:13
Last File Submission Date[2]	02/22/2018 11:41
Last Batch ID Processed[3]	218890
Eligible Discharges	467
Sample Size	160
Survey Mode	Mail only
Determination of Service Line	V.31, V.30, V.29, V.28 V.27, V.26 or V.25 MS-DRG codes
Type of Sampling	Proportionate Stratified Random Sample (PSRS)

Section 9: Public Reporting

Background

Section 1886(s)(4)(E) of the Social Security Act requires the Secretary of HHS to establish procedures for making the data submitted under the PCHQR Program available to the public.

HHS hosts the *Hospital Compare* website, http://www.hospitalcompare.hhs.gov/, which publicly reports hospital performance on numerous measures. *Hospital Compare* is 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 of care data publicly displayed on a rolling quarter basis. The data are published four times each year beginning in December 2014 and subsequent Program Years. The following table displays the upcoming releases of *Hospital Compare* and the PCHQR Program data that will be refreshed with each release. Prior data will continue to display until refreshed by newer data.

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

PCH-1	Adjuvant Chemotherapy is Considered or Administered with Positive Lymph Node Colon Cancer
PCH-2	Combination Chemotherapy is Considered or Administered with T1cN0M0 or Stage IB–III Hormone Receptor Negative Breast Cancer
PCH-3	Adjuvant Hormonal Therapy
PCH-14	Radiation Dose Limits to Normal Tissues*
PCH-15	Plan of Care for Pain
PCH-16	Pain Intensity Quantified
PCH-17	Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients**
PCH-18	Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
PCH-25	External Beam Radiotherapy for Bone Metastases
PCH-29	HCAHPS

Hospital Compare Release	Measures	Quarters Displayed
February 2019	PCH-1, PCH-2	Q4 2016 and Q1, Q2, Q3 2017
	PCH-3	Q2, Q3, Q4 2016 and Q1 2017
	PCH-29	Q2, Q3, Q4 2017 and Q1 2018
	PCH-14*, PCH-15, PCH-16, PCH-17, PCH-18, and PCH-25	Q1, Q2, Q3, Q4 2017
April 2019	PCH-1, PCH-2	Q1, Q2, Q3, Q4 2017£
	PCH-3	Q3, Q4 2016 and Q1, Q2 2017
	PCH-29	Q3, Q4 2017 and Q1, Q2 2018
July 2019	PCH-3	Q4 2016 and Q1, Q2, Q3 2017
	PCH-29	Q4 2017 and Q1, Q2, Q3 2018

*The diagnosis cohort for PCH-14 (NQF #0382) is expanded in the data refreshed in February 2019 to include breast and rectal cancers, in addition to the previously-included lung and pancreatic cancers.

£These are the last set of quarters that will be displayed on *Hospital Compare* for PCH-1 and PCH-2.

Based on the FY 2019 final rule, the following timeline has been established for future public reporting and *Hospital Compare* releases.

Summary of Previously Adopted and Newly Finalized Public Display Requirements	
Measures	**Public Reporting Years**
• Adjuvant Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer (NQF #0223) (PCH-1)* • Combination Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis for Women Under 70 with AJCC T1cN0M0, or Stage IB–III Hormone Receptor Negative Breast Cancer (NQF #0559) (PCH-2)*	2014 and subsequent years
• Adjuvant Hormonal Therapy (NQF #0220) (PCH-3)**	2015 and subsequent years
• Oncology: Radiation Dose Limits to Normal Tissues (NQF #0382) (PCH-14)*** • Oncology: Plan of Care for Moderate to Severe Pain (NQF #0383) (PCH-15) • Oncology: Pain Intensity Quantified (NQF #0384) (PCH-16) • Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer (NQF #0390) (PCH-17) • Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Patients (NQF #0389) (PCH-18) • HCAHPS (NQF #0166) (PCH-29)	2016 and subsequent years
• SSI (NQF#0753) (PCH-6 [colon] and PCH-7 [abdominal hysterectomy]) • MRSA (NQF #1716) (PCH-27) • CDI (NQF #1717) (PCH-26) • Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (NQF #0431) (PCH-28)	As soon as practicable
• CAUTI (NQF #0139) (PCH-5) • CLABSI (NQF #0138) (PCH-4)	Deferred
• External Beam Radiotherapy for Bone Metastases (PCH-25)	2017 and subsequent years

*PCH-1 and PCH-2 will no longer be publicly reported on *Hospital Compare* effective July 2019.
**PCH-3 will no longer be publicly reported on *Hospital Compare* effective October 2019.
***For display for the FY 2019 Program Year and subsequent years, the expanded cohort (containing breast and rectal cancer) was displayed in February 2019.

Preview Period

Prior to the public release of data on the CMS *Hospital Compare* website, facilities are given the opportunity to preview data for 30 days. Preview data will be accessible for download by the facility from the *QualityNet Secure Portal*. Providers will be notified via ListServe when the preview data are available.

Public Reporting (PR) User Interface (UI)

The UI was developed to allow providers increased flexibility in reviewing their data. The format of the site was designed to be similar to *Hospital Compare*.

Users must be enrolled and proofed in the *QualityNet Secure Portal* in order to access the UI. Follow the instructions below to gain access:
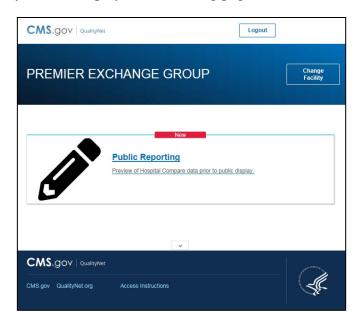
1. Access the public website for *QualityNet* at https://www.qualitynet.org.
2. Select **Login** under the *Log in to QualityNet Secure Portal* header.
3. From the **Choose Your QualityNet Destination** dashboard, select **HQR Next Generation.**

4. Enter your *QualityNet* user ID, password, and security code. Then, select **Submit**.
5. Read the Terms and Conditions statement and select **I Accept** to proceed.

   NOTE: If **I Decline** is selected, the program closes.

6. A card layout will display on the landing page. Select **Public Reporting**.

7. Your provider name and CMS Certification Number (CCN) will appear at the top of the UI. The **Change Facility** button is available to users with roles associated with multiple facilities to view a different provider's data.

8. There are two tabs: Star Rating and Measure Data.

9. Once within PR, users will be able to easily view their data during the 30-day preview period. This page is an interactive analogue to the traditional PDFs. On this page, users can easily view measures associated by measure group, search the entire page for individual measures, dynamically filter through data, and export measure data. The exported measure data will be in PDF format for a user-friendly printed report.

Export Data - Export measure data into a PDF format for a user-friendly printed report.

Search - Enter specific measures into this field, and the UI will dynamically filter for the appropriate content.

Filtering - Filter benchmark data in the following ways:

- Release - Select the release data to be viewed

- Level - Filter whether your facility's data will be compared to the "State" or "National" average during filtering. This functionality is disabled currently and will be activated in a future release.

- Performance - Filter whether your facility's data are filtered for being "Above," "Below," or the "Same" as previous level selection. This functionality is disabled currently and will be activated in a future release.

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 *Hospital Compare*.

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 the *Hospital Compare* home page by selecting the **Resources** button, located between the **About the Data** and **Help** buttons, directly above the *Find a Hospital* selection area. Select the **Information for hospitals.** Once the screen refreshes, select the **CASPER/ASPEN** (Automated Survey Processing Environment) contacts link from the left-side navigation pane: http://www.medicare.gov/HospitalCompare/Resources/CASPER.aspx. 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) and the National Quality Forum (NQF) numbers, which are displayed on *Hospital Compare,* have been provided to assist in measure identification. However, neither will display on the Preview. The measure descriptions are modified for reporting purposes.

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 *Hospital Compare*.

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 the *Hospital Compare* home page by

selecting the **Resources** button, located between the **About the Data** and **Help** buttons, directly above the *Find a Hospital* selection area. Select the **Information for hospitals.** Once the screen refreshes, select the **CASPER/ASPEN** (Automated Survey Processing Environment) contacts link from the left-side navigation pane: http://www.medicare.gov/HospitalCompare/Resources/CASPER.aspx. 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) and the National Quality Forum (NQF) numbers, which are displayed on *Hospital Compare,* 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 *QualityNet Secure Portal* access that the user has.

The accordions are labeled similar to the tabs on *Hospital Compare* and can be expanded by selecting the (+) to the left of the title. Selecting the (-) will collapse the table. Once the accordion is expanded, the measures and data will display.

Cancer Specific Treatment		
	Numerator	Denominator
ℹ PCH-1	14	16
ℹ PCH-2	57	60
ℹ PCH-3	428	452

Oncology Care		
	Facility Rate	Number of Patients
ℹ PCH-14	100% *	69 *
ℹ PCH-15	100% *	100 *
ℹ PCH-16	94% *	384 *
ℹ PCH-17	94% *	36 *
ℹ PCH-18	91% *	34 *

External Beam Radiotherapy		
	Facility Rate	Number of Patients
ℹ PCH-25	97% *	100 *

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

PCH-3: Details

Description:

Adjuvant Hormonal Therapy

Reporting Period:

Q2 (2016) - Q1 (2017)

Cancel

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.

	Numerator	Denominator
ℹ️ **PCH-3**	190 *	40 *

PCH-3: Numerator Details	PCH-3: Denominator Details
✖ Close	✖ Close
Footnote(s)	**Footnote(s)**
(4) - Data suppressed by CMS for one or more quarters.	(6) - Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
Cancel	Cancel

Footnotes

There are instances where footnotes are necessary to clarify data displayed in the preview report. Four 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 *Hospital Compare.*

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

Footnote 5   Results are not available for this reporting period.
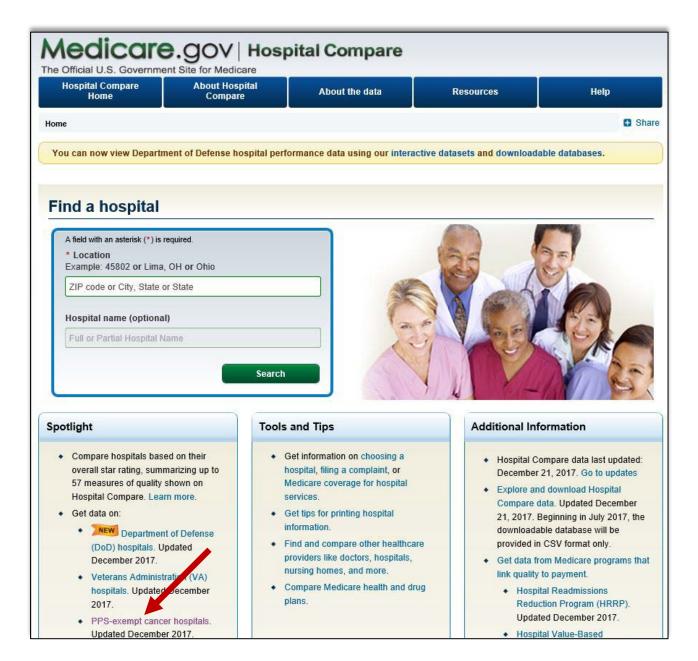
Footnote 7   No cases meet the criteria for this measure.

Medicare.gov Website

Direct Link: http://medicare.gov/hospitalcompare/search.html

Medicare.gov *Home Page* – Hospital Compare

1. Scroll down to the **Spotlight** section.

2. Select the **Get PPS-exempt cancer hospital data** link.
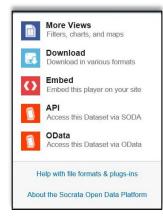
The PCHQR Program page includes a brief description of the program and the measures. The data are in an aggregate annualized format of the quarters for the reporting period.

3. Scroll down the page to see the next section, *Data — By Facility*. The upper left corner of the data table is labeled as *Data.Medicare.gov*.

4. Open the drop-down menu in the top right corner. The drop-down contains options to sort and filter data.

5. After selecting from the menu list, access the **Download** option.

Once the download is complete, filtering and other types of data manipulation are available depending on the file format selected. An alternate method to access the data is to access the *Data.Medicare.gov* website at http://data.medicare.gov

The data displayed on *Hospital Compare* is public. You, other PCHQR Program participants, patients, and providers can see your data and the data from other PCHs.

6. Scroll across the page to see the measures and associated data results.

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 *Hospital Compare.*

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

Footnote 5 Results are not available for this reporting period.

Footnote 7 No cases meet the criteria for this measure.

Section 10: Resources

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

For resources and tools from the PCHQR Program SC, 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 by CMS and by the PCHQR Program SC 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, navigate to the *Join ListServes* box and select the **Notifications and Discussions** link. Enter your 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 CMS 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 *QualityNet* from the *Questions & Answers* section on the right side of the page and then selecting the **PPS-Exempt Cancer Hospitals** link. The direct link is https://cms-ip.custhelp.com/app/homepch/p/830.

If needed information is not found in the 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).

Help Desk - *QualityNet*

For technical issues contact the *QualityNet Help Desk* call toll-free (866) 288-8912 between the hours of 7 a.m. and 7 p.m. CT, or email qnetsupport@hcqis.org.

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://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772864217.

The *QualityNet* home page (www.QualityNet.org) offers a User Guide for the *Secure Portal* and User Guide for the *Secure Portal* reports. Links are located on the right side of the webpage, just below *Log in to QualityNet Secure Portal* at http://www.QualityNet.org/dcs/ContentServer?pagename=QnetPublic/Page/QnetHomepage.

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 *PPS-Exempt Cancer Hospital Measure Data Collection* section at https://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774479863.

Other Resources

Additional resources are located on *QualityNet* at https://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772864228.

Appendix A: PCHQR Program Measure Submission Deadlines by Due Date

Data must be submitted no later than 11:59 p.m. Pacific Time on the submission deadline. Only data submitted according to the Centers for Medicare & Medicaid Services (CMS) established deadlines qualify for inclusion in the PCHQR Program. The reference periods noted for Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (SSI), Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia, and *Clostridium difficile* Infection (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 National Quality Forum designations, please visit the *QualityNet* PCHQR Program Measures web page.

Due Date	Adjuvant Hormonal Therapy*	CLABSI/CAUTI/ SSI/MRSA/CDI**	HCP Flu Vac**	HCAHPS	OCM†‡	EBRT†‡	DACA
01/03/2019	N/A		N/A	Q3 2018 (7/1–9/30)	N/A	N/A	N/A
02/15/2019	Q4 2017 (10/1–12/31)	Q3 2018 (7/1–9/30)	N/A	N/A	N/A	N/A	N/A
04/03/2019	N/A	N/A	N/A	Q4 2018 (10/1–12/31)	N/A	N/A	N/A
05/15/2019	N/A	Q4 2018 (10/1–12/31)	Q4 2018–Q1 2019 (10/1/18–3/31/19)	N/A	N/A	N/A	N/A
07/03/2019	N/A	N/A	N/A	Q1 2019 (1/1–3/31)	N/A	N/A	N/A
08/15/2019	N/A	Q1 2019 (1/1–3/31)	N/A	N/A	CY 2018 (1/1–12/31)	CY 2018 (1/1–12/31)	N/A
09/03/2019	N/A	N/A	N/A	N/A	N/A	N/A	For FY 2020
10/02/2019	N/A	N/A	N/A	Q2 2019 (4/1–6/30)	N/A	N/A	N/A
11/15/2019	N/A	Q2 2019 (4/1–6/30)	N/A	N/A	N/A	N/A	N/A
01/02/2020	N/A	N/A	N/A	Q3 2019 (7/1–9/30)	N/A	N/A	N/A

* Data entered into American College of Surgeons Rapid Quality Reporting System, extracted, and then submitted to CMS via the *QualityNet Secure Portal* at *www.QualityNet.org*

** Submitted to the Centers for Disease Control and Prevention via the National Healthcare Safety Network

† Submitted to CMS via the *QualityNet Secure Portal* at *www.QualityNet.org*

‡ Annual submission, stratified by quarter

Acronyms: CY=Calendar Year; DACA=Data Accuracy and Completeness Acknowledgement; EBRT=External Beam Radiotherapy for Bone Metastases; FY=Fiscal Year; HCAHPS=Hospital Consumer Assessment of Healthcare Providers and Systems; HCP Flu Vac=Influenza Vaccination Coverage Among Healthcare Personnel; OCM=Oncology Care Measure; Q=Quarter

This reference document for PCHQR Program participants provides the following:
- Specific measures with their National Quality Forum (NQF) and PPS-exempt cancer hospital (PCH) number
- 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
- Time frames when each metric will be displayed for Public Reporting on the *Hospital Compare* website

Cancer-Specific Treatment	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters	Quarterly Data Submission Deadlines	*Hospital Compare* Release October 2016	*Hospital Compare* Release December 2016	*Hospital Compare* Release April 2017	*Hospital Compare* Release July 2017	*Hospital Compare* Release October 2017	*Hospital Compare* Release December 2017	*Hospital Compare* Release April 2018	*Hospital Compare* Release July 2018	*Hospital Compare* Release October 2018	*Hospital Compare* Release February 2019	*Hospital Compare* Release April 2019
Colon Cancer NQF #0223 (PCH–1) Breast Cancer NQF #0559 (PCH–2)	2014	1Q 2013	PRIOR											
	2014	2Q 2013	PRIOR											
	2014	3Q 2013	PRIOR											
	2014	4Q 2013	PRIOR											
	2015	1Q 2014	PRIOR											
	2015	2Q 2014	PRIOR											
	2015	3Q 2014	PRIOR											
	2015	4Q 2014	PRIOR	3Q 2014–2Q 2015										
	2016	1Q 2015	PRIOR		4Q 2014–3Q 2015									
	2016	2Q 2015	PRIOR			1Q 2015–4Q 2015								
	2016	3Q 2015	PRIOR				2Q 2015–1Q 2016							
	2016	4Q 2015	PRIOR					3Q 2015–2Q 2016						
	2017	1Q 2016	PRIOR						4Q 2015–3Q 2016					
	2017	2Q 2016	PRIOR							1Q 2016–4Q 2016				
	2017	3Q 2016	PRIOR								2Q 2016–1Q 2017			
	2017	4Q 2016	PRIOR									3Q 2016–2Q 2017		
	2018	1Q 2017	PRIOR										4Q 2016–3Q 2017	
	2018	2Q 2017	PRIOR											1Q 2017–4Q 2017
	2018	3Q 2017	PRIOR											
	2018	4Q 2017	PRIOR											

NOTE: Gray box indicates activity complete; Q=Quarter

Cancer-Specific Treatment	Program (Fiscal) Years	Reporting Periods– Calendar Year Quarters	Quarterly Data Submission Deadlines	Hospital Compare Release December 2016	Hospital Compare Release April 2017	Hospital Compare Release July 2017	Hospital Compare Release October 2017	Hospital Compare Release December 2017	Hospital Compare Release April 2018	Hospital Compare Release July 2018	Hospital Compare Release October 2018	Hospital Compare Release February 2019	Hospital Compare Release April 2019	Hospital Compare Release July 2019	Hospital Compare Release October 2019
Adjuvant Hormonal Therapy NQF #0220 (PCH–3)	2014	1Q 2013	PRIOR												
		2Q 2013	PRIOR												
		3Q 2013	PRIOR												
		4Q 2013	PRIOR												
	2015	1Q 2014	PRIOR												
		2Q 2014	PRIOR	2Q 2014–1Q 2015											
		3Q 2014	PRIOR		3Q 2014–2Q 2015										
		4Q 2014	PRIOR			4Q 2014–3Q 2015									
	2016	1Q 2015	PRIOR				1Q 2015–4Q 2015								
		2Q 2015	PRIOR					2Q 2015–1Q 2016							
		3Q 2015	PRIOR						3Q 2015–2Q 2016						
		4Q 2015	PRIOR							4Q 2015–3Q 2016					
	2017	1Q 2016	PRIOR								1Q 2016–4Q 2016				
		2Q 2016	PRIOR									2Q 2016–1Q 2017			
		3Q 2016	PRIOR										3Q 2016–2Q 2017		
		4Q 2016	PRIOR											4Q 2016–3Q 2017	
	2018	1Q 2017	PRIOR												1Q 2017–4Q 2017
		2Q 2017	PRIOR												
		3Q 2017	PRIOR												
		4Q 2017	PRIOR												

NOTE: Gray box indicates activity complete; Q=Quarter

Safety and Healthcare-Associated Infection (HAI)	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters	Quarterly Data Submission Deadlines	Hospital Compare Release October 2016	Hospital Compare Release December 2016	Hospital Compare Release April 2017	Hospital Compare Release July 2017	Hospital Compare Release October 2017	Hospital Compare Release December 2017	Hospital Compare Release April 2018	Hospital Compare Release July 2018	Hospital Compare Release October 2018	Hospital Compare Release February 2019	Hospital Compare Release April 2019	Hospital Compare Release July 2019
Central Line-Associated Bloodstream Infection (CLABSI) NQF #0139 (PCH–4) Catheter-Associated Urinary Tract Infection (CAUTI) NQF #0138 (PCH–5)	2015	1Q 2014	PRIOR												
		2Q 2014	PRIOR												
		3Q 2014	PRIOR												
		4Q 2014	PRIOR												
	2016	1Q 2015	PRIOR												
		2Q 2015	PRIOR												
		3Q 2015	PRIOR												
		4Q 2015	PRIOR												
	2017	1Q 2016	PRIOR												
		2Q 2016	PRIOR	Public Reporting has been deferred until a later date, as indicated in the Fiscal Year (FY) 2018 Hospital Inpatient Prospective Payment Systems (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule.											
		3Q 2016	PRIOR												
		4Q 2016	PRIOR												
	2018	1Q 2017	PRIOR												
		2Q 2017	PRIOR												
		3Q 2017	PRIOR												
		4Q 2017	PRIOR												
	2019	1Q 2018	PRIOR												
		2Q 2018	PRIOR												
		3Q 2018	PRIOR												
		4Q 2018	PRIOR												
	2020	1Q 2019	08/15/2019												
		2Q 2019	11/15/2019												
		3Q 2019	02/15/2020												
		4Q 2019	05/15/2020												

NOTE: Gray box indicates activity complete; Q=Quarter

Safety and HAI	Program (Fiscal) Years	Reporting Periods– Calendar Year Quarters	Quarterly Data Submission Deadlines	*Hospital Compare Release October 2016*	*Hospital Compare Release December 2016*	*Hospital Compare Release April 2017*	*Hospital Compare Release July 2017*	*Hospital Compare Release October 2017*	*Hospital Compare Release December 2017*	*Hospital Compare Release April 2018*	*Hospital Compare Release July 2018*	*Hospital Compare Release October 2018*	*Hospital Compare Release February 2019*	*Hospital Compare Release April 2019*	*Hospital Compare Release July 2019*
Surgical Site Infection (SSI) NQF #0753 (PCH–6 is colon, and PCH–7 is abdominal hysterectomy.)	2015	1Q 2014	PRIOR												
		2Q 2014	PRIOR												
	2016	3Q 2014	PRIOR												
		4Q 2014	PRIOR												
	2017	1Q 2015	PRIOR												
		2Q 2015	PRIOR												
		3Q 2015	PRIOR												
		4Q 2015	PRIOR												
	2018	1Q 2016	PRIOR	In the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41622), CMS modified its policy in that performance data will be provided as soon as practicable. That is, if available sooner than CY 2019, useable data will be publicly reported on *Hospital Compare* via the next available *Hospital Compare* release.											
		2Q 2016	PRIOR												
		3Q 2016	PRIOR												
		4Q 2016	PRIOR												
	2019	1Q 2017	PRIOR												
		2Q 2017	PRIOR												
		3Q 2017	PRIOR												
		4Q 2017	PRIOR												
	2020	1Q 2018	PRIOR												
		2Q 2018	PRIOR												
		3Q 2018	PRIOR												
		4Q 2018	PRIOR												
	2021	1Q 2019	08/15/2019												
		2Q 2019	11/15/2019												
		3Q 2019	02/15/2020												
		4Q 2019	05/15/2020												

NOTE: Gray box indicates activity complete; Q=Quarter

Safety and HAI	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters	Quarterly Data Submission Deadlines	Hospital Compare Release October 2016	Hospital Compare Release December 2016	Hospital Compare Release April 2017	Hospital Compare Release July 2017	Hospital Compare Release October 2017	Hospital Compare Release December 2017	Hospital Compare Release April 2018	Hospital Compare Release July 2018	Hospital Compare Release October 2018	Hospital Compare Release February 2019	Hospital Compare Release April 2019	Hospital Compare Release July 2019
CDI NQF #1717 (PCH–26) MRSA NQF #1716 (PCH–27)	2018	1Q 2016	PRIOR												
		2Q 2016	PRIOR												
		3Q 2016	PRIOR												
		4Q 2016	PRIOR												
	2019	1Q 2017	PRIOR	In the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41622), CMS modified its policy in that performance data will be provided as soon as practicable. That is, if available sooner than CY 2019, useable data will be publicly reported on *Hospital Compare* via the next available *Hospital Compare* release.											
		2Q 2017	PRIOR												
		3Q 2017	PRIOR												
		4Q 2017	PRIOR												
	2020	1Q 2018	PRIOR												
		2Q 2018	PRIOR												
		3Q 2018	PRIOR												
		4Q 2018	PRIOR												
	2021	1Q 2019	08/15/2019												
		2Q 2019	11/15/2019												
		3Q 2019	02/15/2020												
		4Q 2019	05/15/2020												

NOTE: Gray box indicates activity complete; CDI=*Clostridium difficile* infection; MRSA=Methicillin-resistant *Staphylococcus aureus* Bacteremia; Q=Quarter

Safety and HAI	Program (Fiscal) Years	Reporting Periods–Calendar Year Quarters	Quarterly Data Submission Deadlines	Hospital Compare Release October 2016	Hospital Compare Release December 2016	Hospital Compare Release April 2017	Hospital Compare Release July 2017	Hospital Compare Release October 2017	Hospital Compare Release December 2017	Hospital Compare Release April 2018	Hospital Compare Release July 2018	Hospital Compare Release October 2018	Hospital Compare Release February 2019	Hospital Compare Release April 2019	Hospital Compare Release July 2019
HCP NQF #0431 (PCH–28)	2018	4Q 2016	PRIOR												
		1Q 2017													
	2019	4Q 2017	PRIOR	In the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41622), CMS modified its policy in that performance data will be provided as soon as practicable. That is, if available sooner than CY 2019, useable data will be publicly reported on *Hospital Compare* via the next available *Hospital Compare* release.											
		1Q 2018													
	2020	4Q 2018	PRIOR												
		1Q 2019													
	2021	4Q 2019	05/15/2020												
		1Q 2020													

NOTE: Gray box indicates activity complete; HCP=Influenza Vaccination Coverage Among Healthcare Personnel; Q=Quarter

Clinical Process/ Oncology Care Measures	Program (Fiscal) Years	Reporting Periods– Calendar Year Quarters	Quarterly Data Submission Deadlines	*Hospital Compare Release December 2016*	*Hospital Compare Releases April 2017, July 2017, and October 2017*	*Hospital Compare Release December 2017*	*Hospital Compare Releases April 2018, July 2018, and October 2018*	*Hospital Compare Release February 2019*	*Hospital Compare Releases April 2019, July 2019, and October 2019*	*Hospital Compare Release January 2020*	*Hospital Compare Releases April 2020, July 2020, and October 2020*	*Hospital Compare Release January 2021*
NQF #0383 (PCH–15)	2016	1Q 2015	PRIOR	1Q 2015– 4Q 2015								
	2017	2Q 2015										
		3Q 2015	PRIOR									
		4Q 2015										
	2018	1Q 2016				1Q 2016– 4Q 2016						
		2Q 2016	PRIOR									
		3Q 2016										
		4Q 2016										
	2019	1Q 2017						1Q 2017– 4Q 2017				
		2Q 2017	PRIOR									
		3Q 2017										
		4Q 2017										
	2020	1Q 2018								1Q 2018– 4Q 2018		
		2Q 2018	08/15/2019									
		3Q 2018										
		4Q 2018										
	2021	1Q 2019										1Q 2019– 4Q 2019
		2Q 2019	08/15/2020									
		3Q 2019										
		4Q 2019										

NOTE: Gray box indicates activity complete; Q=Quarter; NQF #0383=Oncology: Plan of Care for Pain—Medical Oncology and Radiation Oncology

Clinical Process/ Oncology Care Measures*	Program (Fiscal) Years	Reporting Periods– Calendar Year Quarters	Quarterly Data Submission Deadlines	*Hospital Compare Release December 2016*	*Hospital Compare Releases April 2017, July 2017, and October 2017*	*Hospital Compare Release December 2017*	*Hospital Compare Releases April 2018, July 2018, and October 2018*	*Hospital Compare Release February 2019*	*Hospital Compare Releases April 2019, July 2019, and October 2019*	*Hospital Compare Release January 2020*
NQF #0382* (PCH–14)	**2016**	1Q 2015	PRIOR	1Q 2015– 4Q 2015						
	2017	2Q 2015								
		3Q 2015	PRIOR							
		4Q 2015								
NQF #0384* (PCH–16)	**2018**	1Q 2016	PRIOR			1Q 2016– 4Q 2016				
		2Q 2016								
		3Q 2016								
NQF #0390* (PCH–17)		4Q 2016								
	2019	1Q 2017	PRIOR					1Q 2017– 4Q 2017		
		2Q 2017								
NQF #0389* (PCH–18)		3Q 2017								
		4Q 2017								
	2020	1Q 2018	08/15/2019							1Q 2018– 4Q 2018
		2Q 2018								
		3Q 2018								
		4Q 2018								

NOTE: Gray box indicates activity complete; Q=Quarter; NQF #0382=Oncology: Radiation Dose Limits to Normal Tissues; NQF #0384=Medical and Radiation—Pain Intensity Quantified; NQF #0390=Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients; NQF #0389=Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

*NQF #s 0382, 0384, 0390, and 0389 were removed in the FY 2019 IPPS/LTCH PPS Final Rule, beginning FY 2021 Program Year.

Clinical Process/ Oncology Care Measures (Claims-Based)	Program (Fiscal) Years	Reporting Periods	*Hospital Compare Release December 2016*	*Hospital Compare Release April 2017*	*Hospital Compare Release July 2017*	*Hospital Compare Release October 2017*	*Hospital Compare Release December 2017*	*Hospital Compare Release April 2018*	*Hospital Compare Release July 2018*	*Hospital Compare Release October 2018*	*Hospital Compare Release February 2019*	*Hospital Compare Release April 2019*	*Hospital Compare Release July 2019*
EOL-Chemo NQF #0210 (PCH–32)	**2020**	Data from 7/1/17 through 6/30/18											
EOL-Hospice NQF #0215 (PCH–34)	**2021**	Data from 7/1/18 through 6/30/19					Public Reporting not addressed in Final Rule						

NOTE: EOL=end of life; 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	*Hospital Compare Release December 2016*	*Hospital Compare Release April 2017*	*Hospital Compare Release July 2017*	*Hospital Compare Release October 2017*	*Hospital Compare Release December 2017*	*Hospital Compare Release April 2018*	*Hospital Compare Release July 2018*	*Hospital Compare Release October 2018*	*Hospital Compare Release February 2019*	*Hospital Compare Release April 2019*	*Hospital Compare Release July 2019*
EOL-ICU NQF #0213 (PCH–33)	**2020**	Data from 7/1/17 through 6/30/18											
EOL-3DH NQF #0216 (PCH–35)	**2021**	Data from 7/1/18 through 6/30/19					Public Reporting not addressed in Final Rule						

NOTE: ICU=intensive care unit; EOL-ICU=Proportion of Patients Who Died from Cancer Admitted to the ICU 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	Quarterly Data Submission Deadlines	Hospital Compare Release December 2016	Hospital Compare Release April 2017	Hospital Compare Release July 2017	Hospital Compare Release October 2017	Hospital Compare Release December 2017	Hospital Compare Release April 2018	Hospital Compare Release July 2018	Hospital Compare Release October 2018	Hospital Compare Release February 2019	Hospital Compare Release April 2019	Hospital Compare Release July 2019	Hospital Compare Release October 2019	Hospital Compare Release January 2020
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey NQF #0166 (PCH–29)	2016	2Q 2014	PRIOR													
		3Q 2014	PRIOR													
		4Q 2014	PRIOR													
	2017	1Q 2015	PRIOR													
		2Q 2015	PRIOR	2Q 2015– 1Q 2016												
		3Q 2015	PRIOR		3Q 2015– 2Q 2016											
		4Q 2015	PRIOR			4Q 2015– 3Q 2016										
	2018	1Q 2016	PRIOR				1Q 2016– 4Q 2016									
		2Q 2016	PRIOR					2Q 2016– 1Q 2017								
		3Q 2016	PRIOR						3Q 2016– 2Q 2017							
		4Q 2016	PRIOR							4Q 2016– 3Q 2017						
	2019	1Q 2017	PRIOR								1Q 2017– 4Q 2017					
		2Q 2017	PRIOR									2Q 2017– 1Q 2018				
		3Q 2017	PRIOR										3Q 2017– 2Q 2018			
		4Q 2017	PRIOR											4Q 2017– 3Q 2018		
	2020	1Q 2018	PRIOR												1Q 2018– 4Q 2018	
		2Q 2018	PRIOR													2Q 2018– 1Q 2019
		3Q 2018	PRIOR													
		4Q 2018	PRIOR													
	2021	1Q 2019	07/03/2019													
		2Q 2019	10/02/2019													
		3Q 2019	01/02/2020													
		4Q 2019	04/01/2020													

NOTE: Gray box indicates activity complete; Q=Quarter

Clinical Effectiveness Measure	Program (Fiscal) Years	Reporting Periods– Calendar Year Quarters	Quarterly Data Submission Deadlines	*Hospital Compare Release July 2017*	*Hospital Compare Release October 2017*	*Hospital Compare Release December 2017*	*Hospital Compare Releases April 2018, July 2018, and October 2018*	*Hospital Compare Release February 2019*	*Hospital Compare Releases April 2019, July 2019, and October 2019*	*Hospital Compare Release January 2020*
External Beam Radiotherapy for Bone Metastases (EBRT) (PCH–25)	2017	1Q 2015	PRIOR	1Q 2015– 4Q 2015						
		2Q 2015								
		3Q 2015								
		4Q 2015								
	2018	1Q 2016	PRIOR			1Q 2016– 4Q 2016				
		2Q 2016								
		3Q 2016								
		4Q 2016								
	2019	1Q 2017	PRIOR					1Q 2017– 4Q 2017		
		2Q 2017								
		3Q 2017								
		4Q 2017								
	2020	1Q 2018	08/15/2019							1Q 2018– 4Q 2018
		2Q 2018								
		3Q 2018								
		4Q 2018								

NOTE: Gray box indicates activity complete; Q=Quarter

Claims Based Outcome Measure	Program (Fiscal) Years	Reporting Periods	*Hospital Compare Release February 2019*	*Hospital Compare Release April 2019*	*Hospital Compare Release July 2019*	*Hospital Compare Release October, February, and April 2019*	*Hospital Compare Release July 2020*
Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (RSAR: PCH–30) (RSEDR: PCH–31)	2019	Data from 7/1/16 through 6/30/17					
	2020	Data from 7/1/17 through 6/30/18			Public Reporting not addressed in Final Rule		

NOTE: RSAR=Risk-Standardized Admission Rate; RSEDR=Risk-Standardized ED Visit Rate

Claims-Based Outcome Measure	Program (Fiscal) Years	Reporting Periods	*Hospital Compare Release February and April 2019*	*Hospital Compare Release July 2019*	*Hospital Compare Release October 2019*	*Hospital Compare Release February and April 2020*	*Hospital Compare Release July 2020*	*Hospital Compare Release October 2020*	*Hospital Compare Release February and April 2021*	*Hospital Compare Release July 2021*	*Hospital Compare Release October 2021*
30-Day Unplanned Readmissions for Cancer Patients NQF #3188	2021	Data from 10/1/18 through 9/30/19	Public Reporting not addressed in Final Rule								

Appendix C: 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.

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.

Reporting Period: The reporting period is the defined time frame 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.