

## **Supporting Statement – Part A**

### **Collection of Information for the Rural Emergency Hospital Quality Reporting (REHQR) Program: CY 2026 OPPS/ASC Proposed Rule (OMB# 0938-1454; CMS-10870)**

#### **A. Background**

This is a revision of the currently approved information collection request. The Centers for Medicare & Medicaid Services' (CMS') quality reporting programs promote higher quality, more efficient healthcare for Medicare beneficiaries by collecting and publicly reporting on quality-of-care metrics. This information is available to consumers including Medicare beneficiaries for their use, for example, toward informed decision-making, as well as to incentivize healthcare facilities to make continued improvements in care quality.

CMS has implemented quality reporting programs for multiple settings, including for rural emergency hospitals (REHs), as authorized by statute, and seeks to achieve overarching priorities and initiatives promoting quality healthcare, such as detailed in the Meaningful Measures 2.0 Framework.<sup>1</sup> The Meaningful Measures 2.0 Framework promotes innovation and modernization of all aspects of quality to better address health care priorities, reduce burden, and increase efficiency: (1) using only high-value quality measures impacting key quality domains; (2) aligning measures across quality programs and across partners, including CMS, federal, and private entities; (3) prioritizing outcome and patient-reported measures; and (4) transforming measures to be fully digital and incorporating all-payer data.

Information collection requirements through the calendar year (CY) 2028 program determination are currently approved under OMB control number 0938-1454 (expiration date December 31, 2026).<sup>2</sup> This request covers data collection requirements for the CY 2028 program determination and subsequent years. This revised information collection request includes burden for the proposed removal of the Hospital Commitment to Health Equity (HCHE), the Screening for Social Drivers of Health (SDOH), and the Screen Positive Rate for SDOH measures, as well as the proposed adoption of the Emergency Care Access & Timeliness electronic clinical quality measure (eCQM).

#### **B. Justification**

##### **1. Need and Legal Basis**

Section 125 of Division CC of the Consolidated Appropriations Act (CAA), 2021, established REHs as a new Medicare provider type.

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<sup>1</sup> <https://www.cms.gov/medicare/quality/cms-national-quality-strategy/meaningful-measures-20-moving-measure-reduction-modernization>

<sup>2</sup> We are using the phrase “program determination” for the REHQR Program to represent our assessment of compliance with program requirements for an applicable year because the REHQR Program does not include an associated payment adjustment.

Section 1861(kkk)(7) of the Act requires the Secretary to establish quality measurement reporting requirements for REHs and establish procedures to make the data available to the public on the CMS website. As discussed further in the CY 2024 OPPTS/ASC final rule (88 FR 82046 through 82076), CMS finalized policies on certain quality measures and quality reporting requirements for REHs.

Section 1861(kkk)(7)(B)(i) of the Act provides that, with respect to each year beginning with 2023 (or each year beginning on or after the date that is 1 year after one or more measures are first specified under subparagraph (C), a REH shall submit data to the Secretary in accordance with clause (ii). Clause (ii) states that, with respect to each such year, a REH shall submit to the Secretary data in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

### **(a) REHQR Program Quality Measures**

We recognize REHs will be smaller facilities that can have limited resources compared with larger facilities in metropolitan areas. To reduce burden, a variety of different data collection mechanisms are employed, with consideration taken to employ data and data collection systems already in place. There are no payment penalties associated with the program; however, similar to the PPS-Exempt Cancer Hospital Quality Reporting Program, REHs are statutorily obligated to report quality measure data.

Publicly reported data on quality-of-care measures as part of the REHQR Program are currently submitted via one of two modes: (1) chart-abstracted; (2) claims-based; and (3) digital, as seen in Table 1. In the CY 2026 OPPTS/ASC proposed rule, we are proposing to allow REHs to begin reporting eCQMs beginning with the CY 2027 reporting period.

For measure data submitted as “chart-abstracted,” information is derived through analysis of a patient’s medical record. Chart-abstracted data involves manual data entry effort and requires some burden.

For measure data submitted as “claims-based,” information is derived through analysis of administrative Medicare Fee-for-Service (FFS) claims and beneficiary enrollment data, and do not require additional effort or burden from facilities.

Measures submitted digitally include electronic clinical quality measures (eCQMs) and those submitted via web-based tools. For eCQMs, information is electronically extracted from electronic health records (EHRs) and/or health information technology (HIT) systems. For measures reported directly to CMS via a web-based tool, REHs are required to submit measure data via CMS’ Hospital Quality Reporting (HQR) system.

**Table 1. Previously Finalized REHQR Program Measures for the CY 2027 Program Determination and Subsequent Years**

<b>Measure Name</b>
<b>Chart-Abstracted Measures</b>
Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients
<b>Claims-Based Measures</b>
Abdomen Computed Tomography (CT) - Use of Contrast Material
Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery
<b>Web-based Tool Submitted Measures</b>
Hospital Commitment to Health Equity*
Screening for Social Drivers of Health*
Screen Positive for Social Drivers of Health*

\*These measures are proposed for removal in the CY 2026 OPPTS/ASC proposed rule.

### **(b) Summary of Proposed REHQR Program Changes**

In the CY 2026 OPPTS/ASC proposed rule, proposed removal of three measures would impact previously approved burden estimates if finalized: (1) the HCHE measure, beginning with the CY 2025 reporting period/CY 2027 program determination; (2) the Screening for SDOH measure, beginning with the CY 2025 reporting period; and (3) the Screen Positive Rate for SDOH measure, beginning with the CY 2025 reporting period. We also proposed to adopt the Emergency Care Access & Timeliness eCQM beginning with the CY 2027 reporting period/CY 2029 program determination as an optional measure.

We also proposed to update the Extraordinary Circumstances Exception (ECE) policy and codify the process for requesting or granting an ECE. This proposed update would explicitly include *extensions* as a type of extraordinary circumstances relief option, in addition to exceptions. Because the process for requesting or granting an ECE would remain the same as the current ECE process, these updates would not affect burden associated with the submission of the ECE form.

### **(c) REHQR Administrative Program Forms**

CMS has implemented procedural requirements that align the hospital, REH, and ASC quality reporting programs, which involve submission of certain forms to comply with program requirements. As a result, many of the forms are used for multiple programs and are included under OMB control number 0938-1022 to reduce administrative burden and the potential for errors when updates are made.

The REHQR Program uses one administrative form: the Extraordinary Circumstances Exception (ECE) Request form, which offers a process for REHs to request an exception to data reporting

requirements when an REH experiences an extraordinary circumstance not within the control of the REH, such as a natural disaster. This form is available online and can be submitted electronically or by fax. This form is completed only on a need-to-use basis and most REHs will not need to complete this form in any given year. Thus, the burden for providers associated with the ECE Request form intended to be utilized in the REHQR Program would be nominal, if any. In the CY 2026 OPPS/ASC proposed rule, we are proposing (1) that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance; and (2) that an REH may request an ECE within 30 calendar days of the date that the extraordinary circumstance occurred; none of which affects collection of information burden under OMB control number 0938-1022.

## **2. Information Users**

CMS uses the submitted data to evaluate the quality of care furnished by participating Rural Emergency Hospitals. The data are analyzed to monitor performance at the individual REH and program levels, and to assess trends across the healthcare system. These insights inform internal program management, guide oversight activities, and support the development of future quality measurement initiatives. In addition, the data are instrumental in identifying patterns that may signal opportunities for improvement in care delivery, disparities in access or outcomes, or unintended consequences of existing policies.

Participating REHs use the data to track their performance over time and to inform internal quality improvement strategies. CMS facilitates this use by furnishing confidential feedback reports and performance summaries that allow providers to compare their results to national benchmarks and peer group averages. These reports help support continuous quality improvement within organizations and align provider efforts with national healthcare priorities.

Additionally, CMS publicly reports selected quality data through consumer-facing tools such as Medicare Care Compare and other CMS.gov platforms. Public reporting increases transparency, promotes accountability, and empowers patients and caregivers to make informed decisions about their healthcare. It also creates an incentive for providers to improve performance by making comparative data accessible to the broader public.

Beyond operational uses, researchers, healthcare organizations, and policymakers may use aggregate, de-identified data to study trends in healthcare quality and to inform future healthcare delivery reforms. These secondary uses underscore the broader value of the program's data collection efforts in shaping an evidence-based, patient-centered healthcare system.

## **3. Use of Information Technology**

To assist REHs in participating in standardized data collection initiatives across the industry, CMS continues to improve data collection tools with the goal of making data submission easier and to increase the utility of the data provided by REHs. CMS employs an established, free data collection tool, the CMS Abstraction and Reporting Tool (CART), for use in collecting data from paper or electronic medical records for chart-abstracted measures. CMS also provides a secure data warehouse via the Hospital Quality Reporting (HQR) system for storage and transmittal of data as well as data validation and aggregation services prior to the release of data to the CMS

website. REHs have the option of using authorized vendors to transmit data. CMS has engaged a national support contractor to provide technical assistance with program requirements and to provide education to support program participants.

In an effort to reduce burden, CMS limits the adoption of measures requiring the submission of patient-level information that must be acquired through chart-abstraction, and employs existing data and data collection systems. These efforts are reflected by the collection and reporting of Medicare claims-based quality measures and quality measures collected via the HQR system. The complete list of measures and data collection forms are organized by type of data collected and data collection mechanism in Table 1.

For Medicare claims-based measures or measures which collect data from claims and other administrative data in part, this section is not applicable, as these measures can be fully calculated based on data already reported to the Medicare program for payment purposes. Therefore, no additional information technology will be required of REHs to collect data for these measures.

#### **4. Duplication of Efforts**

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect quality of care data for REH care. CMS requires REHs to submit quality measure data for services provided in the REH setting. We prioritize efforts to reduce reporting burden for the collection of quality-of-care information by utilizing electronic data that REHs potentially collect for reporting for accreditation.

#### **5. Small Business**

Information collection requirements are designed to allow maximum flexibility to REHs participating in the REHQR Program.

The Health Resources and Services Administration's (HRSA) Medicare Rural Hospital Flexibility Program (Flex) and Medicare Beneficiary Quality Improvement Project (MBQIP), as well as CMS' Quality Improvement Organizations (QIO), provide technical assistance to rural providers to improve healthcare quality. We also provide a help-desk hotline for troubleshooting and 24/7 free information available on the QualityNet website through a Questions and Answers function. This effort can assist REHs in gathering information for their own quality improvement efforts.

#### **6. Less Frequent Collection**

We have designed the collection of quality-of-care data to be the minimum necessary for calculation of summary figures that are reliable estimates of individual REH performance. Under the REHQR Program, REHs are required to submit CMS chart-abstracted, claims-based, and web-based measure data on a quarterly or annual basis relevant to their reporting period. The

following table (Table 2) details the frequency of data submission to CMS by measure type for the REHQR Program.

**Table 2. Frequency of Data Submission Under the REHQR Program by Measure Type**

Measure Type	Frequency of Data Submission
Chart-abstracted	Quarterly
Web-based	Annually

Claims-based measures are calculated from Medicare FFS and beneficiary data; REHs submit claims for reimbursement per claims processing timeliness requirements.

## **7. Special Circumstances**

There are no special circumstances for the REHQR Program.

## **8. Federal Register Notice/Outside Consultation**

A 60-day Federal Register notice for this data collection was published on July 17, 2025 (90 FR 33476).

Section 1890A of the Act requires CMS to consider input on the selection of quality and efficiency measures from a multi-stakeholder group convened by the “consensus-based entity.” To fulfill this requirement, the Partnership for Quality Measurement (PQM) provides input on the Measures under Consideration (MUC) list as part of the Pre-Rulemaking Measure Review (PRMR). We refer readers to <https://p4qm.org/PRMR/About> for more information on the PRMR process.

CMS is additionally supported in quality reporting program efforts by The Joint Commission, CDC, HRSA, and the Agency for Healthcare Research and Quality. These organizations consult with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making collected information accessible, understandable, and relevant to the public. CMS also regularly engages interested parties through the solicitation of comments in rulemaking.

## **9. Payment/Gift to Respondent**

The statutory authority for the REHQR Program does not require the Secretary to provide incentives for submitting quality measure data under the REHQR Program, nor does it require the Secretary to impose penalties for failing to comply with quality reporting program requirements under the REHQR Program. No other payments or gifts will be given to REHs for participation.

## **10. Confidentiality**

We pledge privacy to the extent provided by law. All information collected under the REHQR Program will be maintained in strict accordance with statutes and regulations governing

confidentiality requirements for CMS data, including the Privacy Act of 1974 (5 U.S.C. 552a), the Health Insurance Portability and Accountability Act (HIPAA), and the Quality Improvement Organizations confidentiality requirements, which can be found at 42 C.F.R. Part 480. In addition, the tools used for transmission of data are considered confidential forms of communication, and there are safeguards in place in accordance with HIPAA Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. Only REH-specific data will be made publicly available as mandated by statute. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted.

Data related to the REHQR Program is housed in the HQR application group. CMS' HQR is a General Support System (GSS) housing protected health information (PHI). Users who access CMS' HQR system are identity-managed to permit access to the system and have role-based restrictions (including log-in and password) to the data they can see. The System of Records Notice (SORN) in use for the quality programs including the REHQR Program is MBD 09-70-0536, as modified on February 14, 2018 (83 FR 6591).

## **11. Sensitive Questions**

There are no questions of a sensitive nature associated with these forms. Case-specific clinical data elements will be collected and are necessary to calculate statistical measures. These statistical measures are the basis of all subsequent improvement initiatives derived from this collection and cannot be calculated without case-specific data. Case-specific data will not be released to the public and are not releasable by requests under the Freedom of Information Act. Only facility-specific data will be released to the public after REHs have had an opportunity to review the data that are to be made public, as mandated by statute. The patient-specific data remaining in the CMS clinical data warehouse after data are aggregated for release for public reporting will continue to be subject to the strict confidentiality regulations in 42 CFR Part 480.

## **12. Burden Estimate (Total Hours & Wages)**

### **(a) Background**

In the CY 2026 OPPTS/ASC proposed rule, we proposed to remove three measures that will impact previously approved burden estimates: (1) the HCHE measure, beginning with the CY 2025 reporting period/CY 2027 program determination; (2) the Screening for SDOH measure, beginning with the CY 2025 reporting period; and the (3) the Screen Positive Rate for SDOH measure, beginning with the CY 2025 reporting period. We also proposed to adopt the Emergency Care Access & Timeliness eCQM beginning with the CY 2027 reporting period/CY 2029 program determination as an optional measure.

We discuss other proposals in the CY 2026 OPPTS/ASC proposed rule which will not affect information collection burden under OMB control number 0938-1454 in section B.1.a.

### **(b) Burden for the CY 2027 Program Determination**

Our currently approved burden estimates are based on the 33 REHs acute care and critical access hospital conversions to REH status as of September 27, 2024. Based on the actual number of

acute care and critical access hospital conversions to REH status as of April 11, 2025, we estimate that 38 REHs will report data to the REHQR Program during the CY 2026 reporting period unless otherwise noted. While the exact number of REHs required to submit data may vary due to status changes to and from an REH, REHs are required by statute to submit quality data. Therefore, for purposes of estimating burden, we assume that all 38 REHs will submit data under the REHQR Program for the CY 2026 reporting period and future years.

OMB has currently approved 3,758 hours under OMB control number 0938-1454, accounting for information collection burden experienced by approximately 33 REHs for the CY 2027 program determination. As shown in Table 2, using our updated assumption of 38 REHs and updated wage rates, we estimate a revised baseline burden of 4,218 hours at a cost of \$197,013 for the CY 2027 program determination. Our burden estimates exclude burden associated with claims-based quality measures, which do not require additional effort or burden from REHs. We also note that any burden related to claims more generally is accounted for under the Health Insurance Common Claims Form and Supporting Regulations under OMB control number 0938-1197 (expiration date October 31, 2027).



**Table 2. Total Burden for the CY 2027 Program Determination**

<i>Measure Set</i>	<i>Estimated time per record (minutes) - CY 2027 program determination</i>	<i>Number reporting quarters per year - CY 2027 program determination</i>	<i>Number of REHs</i>	<i>Average number records per REH per quarter</i>	<i>Annual burden (hours) per REH</i>	<i>Total Burden Hours for CY 2027 program determination</i>
<b>Chart-Abstracted Measures</b>						
Median Time for Discharged ED Patients	2.9	4	38	63	12.2	464
<b>Web-Based Measures</b>						
Hospital Commitment to Health Equity	10	1	38	1	0.167	6
Screening for Social Drivers of Health (Survey)	2	1	112,081	1	0.033	3,736
Screening for Social Drivers of Health (Reporting)	10	1	38	1	0.167	6
Screen Positive for Social Drivers of Health	10	1	38	1	0.167	6
<b>Web-Based Measures Subtotal</b>						
<b>Claims-Based Measures</b>	0	0	38	0	0	0
<b>Total Burden Hours</b>						<b>4,218</b>
<b>Total Burden @ Individual labor rate (\$25.63)*</b>						<b>\$170,474</b>
<b>Total Burden @ Medical Records Specialist labor rate (\$55.06)</b>						<b>\$26,539</b>

\*We determine the cost for patients (or their representative) undertaking administrative and other tasks, such as filling out a survey or intake form, using a post-tax wage of \$25.63/hr based on the report “Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices,” which identifies the approach for valuing time when individuals undertake activities on their own time.<sup>3</sup> To derive the costs for patients (or their representatives), a measurement of the usual weekly earnings of wage and salary workers of \$1,192 is divided by 40 hours to calculate an hourly pre-tax wage rate of \$29.80/hr.<sup>4</sup> This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 14 percent calculated by comparing pre- and post-tax income,<sup>5</sup> resulting in the post-tax hourly wage rate of \$25.63/hr. Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs because the individuals’ activities, if any, would occur outside the scope of their employment.

<sup>3</sup> Office of the Assistant Secretary for Planning and Evaluation, Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices, September 17, 2017. Available at <https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework>.

<sup>4</sup> Bureau of Labor and Statistics, Usual Weekly Earnings of Wage and Salary Workers, Fourth Quarter 2024. Available at <https://www.bls.gov/news.release/pdf/wkyeng.pdf>. Accessed April 16, 2024

<sup>5</sup> U.S. Census Bureau, End of Pandemic-Era Expanded Federal Tax Programs Results in Lower Income, Higher Poverty, September 12, 2023. Available at <https://www.census.gov/library/stories/2023/09/median-household-income.html>. Accessed April 16, 2024

### **(c) Updated Hourly Wage Rate**

The most recent data from the Bureau of Labor Statistics May 2024 National Occupational Employment and Wage Estimates reflects a mean hourly wage of \$27.53 per hour for medical records specialists working in “general medical and surgical hospitals” (SOC 29-2072).<sup>6</sup> We calculated the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage, consistent with previous years. This is a rough adjustment, both because fringe benefits and overhead costs vary significantly by employer and methods of estimating these costs vary widely in the literature. Nonetheless, we believe that doubling the hourly wage rate ( $\$27.53 \times 2 = \$55.06$ ) to estimate total cost is a reasonably accurate estimation method. Accordingly, unless otherwise specified, we will calculate cost burden to REHs using a wage plus benefits estimate of \$55.06 per hour throughout the discussion in this section of this rule for the REHQR Program.

### **(d) Chart-Abstracted Measures Burden**

For the CY 2026 reporting period/CY 2028 program determination, the chart-abstracted measure set for the REHQR Program is comprised of the Median Time from ED Arrival to ED Departure for Discharged ED Patients measure. In the CY 2026 OPPI/ASC proposed rule, we proposed that if the proposed Emergency Care Access & Timeliness eCQM is finalized, beginning with the CY 2027 reporting period, REHs would be provided the option to report either the Emergency Care Access & Timeliness eCQM or the Median Time from ED Arrival to ED Departure for Discharged ED Patients measure to meet program requirements.

We continue to assume that for chart-abstracted measures where patient-level data are submitted directly to CMS, it will take an estimated 2.9 minutes, or 0.049 hours, per case per measure to collect and submit the data for each submitted case. Further, based on sample size requirements for the similar measure in the Hospital OQR Program, we assume that each REH will abstract and submit data from 63 cases per quarter, for a total of 252 cases per year. Therefore, we estimate that it will take approximately 12.2 hours (0.049 hours x 252 cases) at a cost of approximately \$672 per REH (12.2 hours x \$55.06) to collect and report data for this measure. Therefore, for all participating REHs, we estimate an annual chart-abstraction burden of 464 hours (12.2 hours x 38 REHs) at a cost of \$25,548 (464 hours x \$55.06).

### **(e) Web-Based Measures Burden**

In the CY 2026 OPPI/ASC proposed rule, we proposed to remove the HCHE, the Screening for SDOH, and the Screen Positive for SDOH measures beginning with the CY 2025 reporting period.

### **(f) eCQM Measures Burden**

In the CY 2026 OPPI/ASC proposed rule, we proposed to adopt the Emergency Care Access & Timeliness eCQM beginning with the CY 2027 reporting period/CY 2029 program determination. Because this would be the first eCQM adopted in the REHQR Program, we also proposed that REHs be provided with the option of reporting either the Median Time for

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<sup>6</sup> U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed April 8, 2025. Available at: <https://data.bls.gov/oes/#!/industry/622100>.

Discharged ED Patients measure or the Emergency Care Access & Timeliness eCQM to meet program requirements. We assume a Medical Records Specialist would require 10 minutes (0.167 hours) to submit the data required per quarter for each REH, therefore, for each REH that elects to report the Emergency Care Access & Timeliness eCQM, we estimate an annual burden of 40 minutes (0.67 hours; 10 minutes x 4 quarters) annually at a cost of \$37 (0.67 hours x \$55.06). Because we are currently unable to estimate the number of REHs that would elect to report the Emergency Care Access & Timeliness eCQM instead of the Median Time for Discharged ED Patients measure, we conservatively include only the higher burden for the Median Time for Discharged ED Patients measure in the total burden summary discussed in section 12.h.

#### **(g) Claims-Based Measures Burden**

Claims-based measures are derived through analysis of administrative claims data and do not require additional effort or burden on behalf of facilities. As a result, the REHQR Program's claims-based measures do not influence our burden calculations.

#### **(h) Total Burden for the CY 2028 Program Determination and Subsequent Years**

As shown in Tables 4 and 5, in summary, under OMB control number 0938-1454, we estimate a total annual information collection burden for 38 REHs of 464 hours at a cost of \$25,548 for the CY 2028 program determination. We also estimate an annual decrease of 12,935 hours and \$333,258 associated with our proposals and updated burden estimates described above related to this information collection (which also reflects updated assumptions and use of updated hourly wage rates as previously discussed), for the CY 2026 reporting period/CY 2028 program determination and subsequent years, compared to our currently approved information collection burden estimates. The tables below summarize the total burden changes for the CY 2028 program determinations and subsequent years compared to our currently approved information collection burden estimates.

**Table 4. Total Burden Hours for the CY 2028 Program Determination and Subsequent Years**

<b>Information Collection</b>	<b>CY 2028</b>	<b>Difference from Currently Approved</b>
Chart-Abstracted Measures	464	61
Web-Based Measures	0	-12,996
eCQM Measures	0	0
Claims-Based Measures	N/A	0
<b>TOTAL</b>	<b>464</b>	<b>-12,935</b>

**Table 5. Total Burden Dollars for the CY 2028 Program Determination and Subsequent Years\***

Information Collection	CY 2028	Difference from Currently Approved
Chart-Abstracted Measures	\$25,548	\$359
Web-Based Measures	\$0	-\$333,617
eCQM Measures	\$0	\$0
Claims-Based Measures	N/A	\$0
<b>TOTAL</b>	<b>\$25,548</b>	<b>-\$333,258</b>

\* Cost estimates are based on updated wage rates. Differences from currently approved burden account for updating estimates of currently approved hours to the new wage rates.

### 13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs being placed on the REHs. CMS is providing a data collection tool and method for submission of data to the participants. There are no additional data submission requirements placing additional cost burdens on REHs.

### 14. Cost to Federal Government

The cost to the Federal Government for maintaining program activities is for supporting data system architecture, data storage, maintenance and updating of information technology infrastructure on the HQR system secure portal, providing ongoing technical assistance to REHs and data vendors, calculation of claims-based measures, measure development and maintenance, the provision of REHs with feedback and preview reports, as well as costs associated with public reporting. These costs are estimated at \$10,050,000 annually for the validation and quality reporting contracts. Additionally, this program takes one CMS staff at a GS-13 Step 5 level to operate. GS-13 Step 5 approximate annual salary is \$136,658 plus benefits (30%) of \$40,997 for a total cost of \$177,655. The total annual cost to the Federal Government is \$10,227,655.

For the claims-based measures, the cost to the Federal Government is minimal. CMS uses data from the CMS National Claims History system that are already being collected for provider reimbursement; therefore, no additional data will need to be submitted by REHs for claims-based measures.

### 15. Program or Burden Changes

We previously requested total annual burden estimates under this OMB control number for the CY 2026 reporting period/CY 2028 program determination of 13,399 hours at a cost of \$341,145 as a result of policies finalized in the CY 2025 OPPTS/ASC final rule. Accounting for updated wage rates, the total cost of \$341,145 increases to \$355,806. For the CY 2026 reporting period/CY 2028 program determination, based on the proposed measure removals and adoptions in the CY 2026 OPPTS/ASC proposed rule, we estimate a total burden of 464 hours at a cost of \$25,548 (a decrease of 3,294 hours and \$79,304 from our estimate in the CY 2025 OPPTS/ASC final rule for the CY 2025 reporting period/CY 2027 program determination).

The removal of the HCHE measure results in a total estimated burden decrease of 6 hours at a cost of \$330 beginning with the CY 2028 program determination. The removal of the Screening

for SDOH and Screen Positive Rate for SDOH measures results in a total estimated burden decrease of 12,984 hours and \$332,957 and 6 hours at a cost of \$330, respectively, beginning with the CY 2028 program determination. As discussed in section 12.f, the proposed adoption of the Emergency Care Access & Timeliness eCQM does not affect our total estimated burden.

Accounting for the impact of the proposed measure removals and adoptions in the CY 2026 OPPS/ASC proposed rule, our updated estimate of the number of REHs results in an annual burden increase of 61 hours and \$359 through the CY 2028 payment determination. For the CY 2028 program determination and subsequent years, due to these measure adoptions, removals, and adjustments, the aggregate decrease in burden hours is -12,935 hours (+61 – 6 – 12,984 - 6) with a decrease of \$333,258 (+\$359 - \$330 - \$332,957 - \$330) as shown in Tables 4 and 5.

## **16. Publication**

As required by the authorizing statute, quality measure data will be made publicly available after providing REHs the opportunity to review their data on data.cms.gov and the Compare tool. The goal of the data collection is to tabulate and publish REH-specific data. CMS will display information on the quality of care provided in the REH setting for public viewing as required by CAA, 2021, beginning in CY 2026. We anticipate updating these data on at least an annual basis. However, in certain circumstances public display may be delayed as we evaluate the accuracy of the measure data.

## **17. Expiration Day**

We will display the approved expiration date on each of the forms included as appendices to this PRA, which will become available on the *QualityNet* website (<https://qualitynet.cms.gov>). We will also display the approved expiration date prominently on the *QualityNet* website's REHQR Program pages used to document our measure specifications and reporting guidance.

## **18. Certification Statement**

We are not claiming any exceptions to the Certification for Paperwork Reduction Act Submissions Statement.

## **19. Collections of Information Employing Statistical Methods**

This information collection does not require the use of statistical methods. However, to reduce burden, facilities may sample using their method of choice to reduce the number of cases for which to submit data.