

Supporting Statement – Part A

Submission of Information for the Rural Emergency Hospital Quality Reporting (REHQR) Program: CY 2025 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 reporting on quality-of-care metrics. This information is made available to consumers, both to empower Medicare beneficiaries and inform decision-making, as well as to incentivize healthcare facilities to make continued improvements.

Specifically, CMS has implemented quality measure 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 National Quality Strategy¹ and Meaningful Measures 2.0 Framework.² In particular, Meaningful Measures 2.0 promotes innovation and modernization of all aspects of quality to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives by supporting five interrelated goals: (1) empower consumers to make good health care choices through patient-directed quality measures and public transparency, (2) leverage quality measures to promote health equity and close gaps in care, (3) streamline quality measurement, (4) leverage measures to drive outcome improvement through public reporting and payment programs, and (5) improve quality measure efficiency by transitioning to digital measures and using advanced data analytics.

The information collection requirements through the calendar year (CY) 2028 program determination are currently approved under OMB control number 0938-1454 (expiration date April 30, 2027).³ This request covers data collection requirements for the CY 2027 program determination and subsequent years. This revised information collection request includes burden for the proposed adoption of the Hospital Commitment to Health Equity (HCHE) measure, the Screening for Social Drivers of Health (SDOH) measure, and the Screen Positive Rate for SDOH measure.

B. Justification

1. Need and Legal Basis

¹ <https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy>

² <https://www.cms.gov/medicare/quality/meaningful-measures-initiative/meaningful-measures-20>

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

Section 1861(kkk)(7) of the Act requires the Secretary to establish quality measurement reporting requirements for REHs. An REH must submit quality measure data to the Secretary with respect to each year beginning in 2023 (or each year beginning on or after the date that is one year after one or more measures are first specified), and the Secretary is required to 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.

More specifically, 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 hospitals that have limited resources compared with larger hospitals in metropolitan areas. In an effort to reduce burden, a variety of different data collection mechanisms are employed, with every 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; and (2) claims-based, as seen in Table 1.

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 from hospitals.

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 hospitals.

Table 1. Previously Finalized REHQR Program Measures for the CY 2026 Program Determination and Subsequent Years

Measure Name	CBE No.
Chart-Abstracted Measures	
Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients	N/A

Measure Name	CBE No.
Claims-Based Measures	
Abdomen Computed Tomography (CT) - Use of Contrast Material	N/A
Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	2539
Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery	2687

(b) Summary of Proposed REHQR Program Changes

In the CY 2025 OPPS/ASC proposed rule, we proposed to adopt three web-based measures that would 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 voluntary reporting for the CY 2025 reporting period, followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 program determination; and the (3) the Screen Positive Rate for SDOH measure, beginning with voluntary reporting for the CY 2025 reporting period, followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 program determination.

We also proposed to extend the reporting period for the previously adopted Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure beginning with the CY 2027 program determination. Because this claims-based measure is calculated using data that are already reported to the Medicare program for payment purposes, there is no burden associated with the collection and submission of data for this measure. Accordingly, our proposal to extend the reporting period from one to two years would not result in additional burden for REHs. In addition, we proposed a requirement for when a REH must begin reporting measures under the REHQR Program.

We did not propose any other measure removals or adoptions, or other policies, which would have an impact on previously approved burden estimates.

(c) REHQR Administrative Program Forms

CMS has implemented procedural requirements that align the hospital and ASC quality reporting programs, including the REHQR, Hospital OQR Program, Ambulatory Surgical Center Quality Reporting (ASCQR), Hospital Inpatient Quality Reporting (IQR), PPS-Exempt Cancer Hospital Quality Reporting (PCHQR), and Inpatient Psychiatric Facility Quality Reporting (IPFQR) Programs, which involve submission of certain forms to comply with program requirements. As a result, many of the forms are used for multiple programs but are included under OMB control number 0938-1022 (expiration date January 31, 2026)⁴ to reduce administrative burden and the potential for errors when updates are necessary.

⁴ This burden is captured under another package because the hospital and ASC quality reporting and value-based purchasing programs use a single request form to avoid the use of multiple forms. Accounting for this burden under a single package ensures that all programs are using the same form, process, and burden estimates and avoids the

The REHQR Program, uses one administrative form: the Extraordinary Circumstances Exception (ECE) Request, which offers a process for REHs to request CMS exceptions to the reporting of required quality data when an REH experiences an extraordinary circumstance not within the control of the REH, such as a natural disaster. This form is found online and can be submitted electronically or by fax. This form would not be completed on an annual basis; it would be on a need-to-use, exception 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. We note that the burden associated with completing and submitting an ECE request is accounted for in a separate PRA package for other quality reporting programs, OMB Control Number 0938-1022 (expiration date January 31, 2026).⁵

2. Information Users

As a quality reporting program, the REHQR Program strives to have a streamlined measure set that provides meaningful measurement that also serves to differentiate facilities by quality of care while limiting burden to the fullest extent possible. The measure information collected will be made available to REHs to assess their performance and operationalize quality improvement activities throughout the quality reporting period. This information will also be made available to Medicare beneficiaries, as well as to the general public, by providing REH information on the Compare tool hosted by HHS, available at: <https://www.medicare.gov/care-compare/>, or its successor website(s) and on data.cms.gov to assist them in making decisions about their healthcare.

CMS will provide confidential feedback reports that REHs may use to assess their performance and operationalize quality improvement activities throughout the quality reporting period. These reports will include data that CMS has collected from the REH and the REH's claims, as well as information about how the REH's data compare to the performance of other REHs. For example, the Facility, State and National (FSN) Report would allow REHs to compare their performance on a specific measure during a specific timeframe to the average performance of other REHs at the state and national levels.

CMS sometimes conducts focus groups or market testing prior to publicly reporting hospital quality data on the Compare tool hosted by HHS or its successor website(s) to get feedback on ways to make the website more user-friendly. Feedback from these focus groups has helped CMS understand how beneficiaries and consumers use the Compare tool hosted by HHS or its successor website(s). Under emergency circumstances, consumers choose hospitals based on proximity, reputation, prior experience, or their doctor's recommendation.

Under section 1890A(a)(6) of the Social Security Act, CMS is required to evaluate the impact and efficiency of CMS measures in quality reporting programs and to post the report every three years. Following the compilation of data from other CMS quality programs, CMS' findings were

risk of inconsistency or misalignment in CMS policies on this issue, as well as reducing inefficiencies in form updates and request processing.

⁵ Ibid.

formally written into the latest triennial National Impact Assessment Report, which was released in 2024.⁶ It is expected that the compilation of data from the REHQR Program will be included in the next triennial National Impact Assessment Report.

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 the REHs. As an example, CMS employs the 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 the data. CMS has engaged a national support contractor to provide technical assistance with program requirements and to provide education to support program participants.

As reflected by the collection and reporting of quality measures calculated from Medicare claims information, efforts are made to reduce burden by limiting the adoption of measures requiring the submission of patient-level information that must be acquired through chart-abstraction and to employ existing data and data collection systems.

The complete list of measures and data collection forms are organized by type of data collected and data collection mechanism in Table 1.

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

5. Small Business

⁶ The latest 2024 Impact Assessment Report, as well as earlier reports from 2012, 2015, 2018, and 2021 may be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/National-Impact-Assessment-of-the-Centers-for-Medicare-and-Medicaid-Services-CMS-Quality-Measures-Reports>.

Information collection requirements are designed to allow maximum flexibility, specifically 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 small hospitals to reduce burden and improve healthcare quality. We also provide a help-desk hotline for troubleshooting purposes 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 to be reliable estimates of individual REH performance. Under the REHQR Program, REHs are required to submit CMS chart-abstracted, claims-based, and potentially 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

*Three measures of this type are proposed in the CY 2025 OPPS/ASC proposed rule.

Claims-based measures are calculated from Medicare FFS claims data; REHs submit claims for reimbursement or payment 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 22, 2024 (89 FR 59437).

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 (e.g. solicitation of comments).

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. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted. 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.

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 hospital-specific data will be released to the public after hospitals have had an opportunity to review the data that are to be made public with respect to the hospital, as

mandated by statute. The patient-specific data remaining in the CMS clinical data warehouse after the 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 2025 OPPS/ASC proposed rule, we proposed to adopt three web-based measures that would 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 voluntary reporting for the CY 2025 reporting period, followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 program determination; and (3) the Screen Positive Rate for SDOH measure, beginning with voluntary reporting for the CY 2025 reporting period, followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 program determination.

We discuss other program updates proposed in the CY 2025 OPPS/ASC proposed rule which would not affect information collection burden under OMB control number 0938-1454 in section B.1.a.

(b) Burden for the CY 2026 Program Determination

Our currently approved burden estimates are based on an assumption that approximately 746 hospitals could convert to REH status assuming that all eligible hospitals in states which have passed or amended necessary legislation enabling conversion to occur as of March 2023 choose to do so and we stated that we would update our estimates once more information was made available. Based on the actual number of acute care and CAH conversions to REH status as of April 22, 2024, we estimate that 25 REHs would report data to the REHQR Program during the CY 2025 reporting period. 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 25 REHs would submit data under the REHQR Program for the CY 2025 reporting period and subsequent years.

OMB has currently approved 9,101 hours at a cost of \$474,344 under OMB control number 0938-1454, accounting for information collection burden experienced by approximately 746 REHs for the CY 2026 program determination. As shown in Table 2, using our updated assumption of 25 REHs and updated wage rates, we estimate a revised baseline burden of 305 hours at a cost of \$16,891 for the CY 2026 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 December 31, 2024).

Table 2. Total Burden for the CY 2026 Program Determination

<i>Measure Set</i>	<i>Estimated time per record (minutes) - CY 2026 program determination</i>	<i>Number reporting quarters per year - CY 2026 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 2026 program determination</i>
Chart-Abstracted Measures						
Median Time for Discharged ED Patients	2.9	4	25	63	12.2	305
Claims-Based Measures	0	0	25	0	0	0
Total Burden Hours						305
Total Burden @ Medical Records Specialist labor rate (\$55.38/hr)						\$16,891

(c) Updated Hourly Wage Rate

The most recent data from the Bureau of Labor Statistics May 2023 National Occupational Employment and Wage Estimates reflects a mean hourly wage of \$27.69 per hour for medical records specialists working in “general medical and surgical hospitals” (SOC 29-2072).⁷ 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 ($\$27.69 \times 2 = \55.38) 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 \$55.38 per hour throughout the discussion in this section of this rule for the REHQR Program.

(d) Chart-Abstracted Measures Burden

For the CY 2025 reporting period/CY 2027 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. 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 \$676 per hospital (12.2 hours x \$55.38/hour) to collect and report data for this measure. Therefore, for all participating REHs, we estimate an annual chart-abstraction burden of 305 hours (12.2 hours x 25 REHs) at a cost of \$16,891 (305 hours x \$55.38/hour).

⁷ U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed April 29, 2024. Available at: <https://www.bls.gov/oes/current/oes292072.htm>.

(e) Web-Based Measures Burden

In the CY 2025 OPPS/ASC proposed rule, we proposed to adopt the HCHE measure beginning with the CY 2025 reporting period/CY 2027 program determination. For this measure, REHs would be required to report on attestations of “yes” or “no” to a set of five domains related to organizational efforts towards health equity once annually using a CMS-designated information system. We estimate the reporting burden associated with this measure to be, on average across all 25 REHs, no more than 10 minutes per REH per year, as we believe the burden for REHs to report this measure would be very similar to the burden for hospital inpatient departments to report the same measure once annually under the Hospital Inpatient Quality Reporting (IQR) Program as approved under OMB control number 0938-1022 (expiration date January 31, 2026). Using an estimate of 10 minutes (or 0.167 hours) per REH per year, we estimate a total annual burden increase of 4 hours ($0.167 \text{ hours} \times 25 \text{ REHs}$) at a cost of \$222 ($4 \text{ hours} \times \$55.38/\text{hour}$) across all REHs.

In the CY 2025 OPPS/ASC proposed rule, we proposed to adopt the Screening for SDOH measure, beginning with voluntary reporting for the CY 2025 reporting period, followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 program determination. For this measure, REHs would be required to report whether they screened patients for five health-related social needs (HRSN).

REHs would be able to collect data for the measure using a self-selected screening tool. We expect that most REHs would likely collect data through a screening tool incorporated into their electronic health record or other patient intake process. We estimate the information collection burden related to conducting patient screening associated with this measure to be 2 minutes (0.033 hours) per patient. This is based on the currently approved burden estimate for the Hospital IQR Program under OMB control number 0938-1022 (expiration date January 31, 2026) for the same measure with patient screening for the same HRSN domains and the same frequency of data reporting.

To provide an estimate of patient volume for the purposes of calculating the information collection burden associated with this measure we utilized data derived from a Definitive Healthcare survey which calculated that Medicare FFS patients account for 35.6 percent of hospital payer mix and a MedPAC report that determined hospitals which have converted to REH status average 4,200 outpatient visits for Medicare FFS beneficiaries to estimate that each year 11,798 ($4,200 \div 35.6 \text{ percent}$) patients would be screened per REH when reporting on the measure becomes mandatory.^{8,9} We therefore estimate a total of approximately 295,000 patients ($11,798 \text{ patients} \times 25 \text{ REHs}$) would be screened across all 25 REHs. As submission rates among facilities may vary, we conservatively estimate that for voluntary reporting for the CY 2025

⁸ Definitive Healthcare, Breaking down U.S. hospital payor mixes, July 14, 2023. Available at <https://www.definitivehc.com/resources/healthcare-insights/breaking-down-us-hospital-payor-mixes>

⁹ Medicare Payment Advisory Commission, Medicare and the Health Care Delivery System, June 2021. Available at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf

reporting period, 50 percent of REHs would survey 50 percent of patients, and beginning with the first mandatory reporting period, REHs would survey 100 percent of patients.

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 \$24.49/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.¹⁰ To derive the costs for patients (or their representatives), a measurement of the usual weekly earnings of wage and salary workers of \$1,139 is divided by 40 hours to calculate an hourly pre-tax wage rate of \$28.48/hr.¹¹ 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,¹² resulting in the post-tax hourly wage rate of \$24.49/hr. Unlike our state and private sector wage adjustments, we are not adjusting patient wages for fringe benefits and other indirect costs since the individuals’ activities, if any, would occur outside the scope of their employment.

For the CY 2025 voluntary reporting period, we estimate a total burden increase for patients of 2,434 hours (295,000 patients × 50 percent response rate × 50 percent of REHs × 0.033 hours per patient) at a cost of \$59,609 (2,434 hours × \$24.49/hour). Beginning with the CY 2026 mandatory reporting period, we estimate an annual total burden increase for patients of 9,735 hours (295,000 patients × 0.033 hours per patient) at a cost of \$238,410 (9,735 hours × \$24.49/hour).

Also in the CY 2025 OPPS/ASC proposed rule, we proposed to adopt the Screen Positive Rate for SDOH measure, beginning with voluntary reporting for the CY 2025 reporting period, followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 program determination. For this measure, REHs would be required to report on the number of patients who screened positive for one or more of the five domains (reported as five separate rates to reflect each of the five HRSN domains) divided by the total number of patients screened. We include the collection burden associated with screening patients in our discussion of the Screening for SDOH measure. Thus, for the Screen Positive Rate for SDOH measure, we estimate only the additional burden for REH reporting via the HQR system since patients would not need to provide, and REHs would not need to collect, any additional information for this measure. We continue to estimate that, for voluntary reporting for the CY 2025 reporting period, 50 percent of REHs would submit data, and beginning with the first mandatory reporting period, 100 percent of REHs would submit data.

¹⁰ 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>.

¹¹ Bureau of Labor and Statistics, Usual Weekly Earnings of Wage and Salary Workers, First Quarter 2024. Available at <https://www.bls.gov/news.release/pdf/wkyeng.pdf>. Accessed April 16, 2024

¹² 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.

For both the Screening for SDOH and Screen Positive Rate for SDOH measures, measure data will be aggregated to the hospital level as a numerator and a denominator and would be submitted via the HQR system annually. Similar to the currently approved burden estimate for the same measure with the same frequency of data reporting for the Hospital IQR Program under OMB control number 0938-1022 (expiration date January 31, 2026), we estimate a burden of 10 minutes (0.167 hours) per measure per REH to report the measure data. With regard to reporting for the CY 2025 voluntary reporting period, we estimate a total collection and reporting burden increase for REHs of 2 hours (25 REHs \times 50 percent of REHs \times 0.167 hours per REH) at a cost of \$111 (2 hours \times \$55.38/hour) for each measure. Beginning with the CY 2026 mandatory reporting period, we estimate a total collection and reporting burden increase for REHs of 4 hours (25 REHs \times 0.167 hours per REH) at a cost of \$222 (4 hours \times \$55.38/hour) for each measure.

Table 3. Estimated Burden for the Web-Based Measure Reporting and Submission Requirements for the CY 2027 through CY 2028 Program Determination Years

<i>Web-Based Measure Reporting</i>	<i>Estimated time per record (minutes)</i>	<i>Number reporting quarters per year</i>	<i>Number of Respondents</i>	<i>Average number records per Respondent per quarter</i>	<i>Annual burden (hours) per Respondent</i>	<i>Total Annual hours for all Respondents</i>
CY 2027 Program Determination						
Hospital Commitment to Health Equity	10	1	25	1	0.167	4
Screening for SDOH (Voluntary Patient Surveys)	2	1	73,750	1	0.033	2,434
Screening for SDOH (Voluntary Reporting)	10	1	13	1	0.167	2
Screen Positive Rate for SDOH (Voluntary Reporting)	10	1	13	1	0.167	2
Total Burden Hours						2,442
Total Burden @ Individual labor rate (\$24.49/hr)						\$59,609
Total Burden @ Medical Records Specialist labor rate (\$55.38/hr)						\$444
CY 2028 Program Determination						
Hospital Commitment to Health Equity	10	1	25	1	0.167	4
Screening for SDOH (Mandatory Patient Surveys)	2	1	295,000	1	0.033	9,735
Screening for SDOH (Mandatory Reporting)	10	1	25	1	0.167	4

Screen Positive Rate for SDOH (Mandatory Reporting)	10	1	25	1	0.167	4
Total Burden Hours						9,747
Total Burden @ Individual labor rate (\$24.49/hr)						\$238,410
Total Burden @ Medical Records Specialist labor rate (\$55.38/hr)						\$666

(e) 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 hospitals. As a result, the REHQR Program's claims-based measures do not influence our burden calculations.

(f) Total Burden for the CY 2027 through CY 2028 Program Determinations

As shown in Tables 4 and 5, in summary, under OMB control number 0938-1454, we estimate a total annual information collection burden increase for 25 REHs of 951 hours associated with our proposed policies and updated burden estimates described above and a total cost decrease related to this information collection of \$248,046 (which also reflects updated assumptions and use of updated hourly wage rates as previously discussed), from the CY 2025 reporting period/CY 2027 program determination through the CY 2026 reporting period/CY 2028 program determination, compared to our currently approved information collection burden estimates. The tables below summarize the total burden changes for the CY 2027 and CY 2028 program determinations compared to our currently approved information collection burden estimates (the columns in each table for the CY 2028 program determination reflects the cumulative burden changes).

Table 4. Total Burden Hours for the CY 2027 through CY 2028 Program Determinations

Information Collection	CY 2027	Difference from Currently Approved	CY 2028	Difference from Currently Approved
Chart-Abstracted Measures	305	-8,796	305	-8,796
Web-Based Measures	2,442	2,442	9,747	9,747
Claims-Based Measures	N/A	0	N/A	0
TOTAL	2,747	-6,354	10,052	951

Table 5. Total Burden Dollars for the CY 2027 through CY 2030 Program Determinations*

Information Collection	CY 2027	Difference from Currently Approved	CY 2028	Difference from Currently Approved
Chart-Abstracted Measures	\$16,891	-\$487,122	\$16,891	-\$487,122
Web-Based Measures	\$60,053	\$60,053	\$239,076	\$239,076
Claims-Based Measures	N/A	\$0	N/A	\$0
TOTAL	\$76,944	-\$427,069	\$255,967	-\$248,046

* 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 \$133,692 plus benefits (30%) of \$40,108 for a total cost of \$173,800. The total annual cost to the Federal Government is \$10,223,800.

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 hospitals for claims-based measures.

15. Program or Burden Changes

We previously requested and received approval for total annual burden estimates under this OMB control number for the CY 2025 reporting period/CY 2027 program determination of 9,101 hours at a cost of \$474,344 as a result of policies finalized in the CY 2024 OPPS/ASC final rule. Accounting for updated wage rates, the total cost of \$474,344 increases to \$504,013. For the CY 2025 reporting period/CY 2027 program determination, based on the policy proposals in the CY 2025 OPPS/ASC proposed rule, we estimate a total burden of 2,747 hours at a cost of \$76,944 (a decrease of 6,354 and \$397,400 from our estimate in the CY 2024 OPPS/ASC final rule for the CY 2024 reporting period/CY 2026 program determination).

The proposed adoption of the HCHE measure would result in a total estimated burden increase of 4 hours at a cost of \$222 beginning with the CY 2027 program determination. The proposed adoption of the Screening for SDOH and Screen Positive Rate for SDOH measures would result in a total estimated burden increase of 9,739 hours at a cost of \$238,632 and 4 hours at a cost of \$222, respectively, when mandatory reporting begins for the CY 2028 program determination.

Accounting for the impact of the proposals in the CY 2025 OPPS/ASC proposed rule, our updated estimate of the number of REHs results in an annual burden decrease of 8,796 hours and \$487,122. From the CY 2027 payment determination through the CY 2028 program determination, due to these policies and adjustments, the aggregate increase in burden hours is 951 hours $(-8,796 + 4 + 9,739 + 4)$ with a decrease of \$248,046 $(-\$487,122 + \$222 + \$238,632 + \$222)$ 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. We note, however, that in certain circumstances we may decide to delay public display as we evaluate the accuracy of the measure data.

17. Expiration Date

We will display the approved expiration date on each of the forms included as appendices to this PRA, which would 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.