Supporting Statement–Part A
Quality Measures and Procedures for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program for the FY 2026 Program Year (CMS-10431)

A. Background

Pursuant to section 1866(k) of the Social Security Act, starting in FY 2014 and for subsequent fiscal years, PPS-exempt cancer hospitals (PCHs), as described in section 1886(d)(1)(B)(v) of the Social Security Act, shall submit pre-defined quality measures to the Centers for Medicare & Medicaid Services (CMS). As CMS's aim is to facilitate high quality of care in a meaningful and effective manner while simultaneously remaining mindful of the reporting burden on the PCHs, CMS intends to reduce duplicative reporting efforts whenever possible by leveraging existing infrastructure.

CMS has implemented procedural requirements that align the current quality reporting programs, including the PCHQR, Hospital Inpatient Quality Reporting (IQR), Hospital Outpatient Quality Reporting, and Hospital Value-Based Purchasing (VBP) Programs. These procedural requirements involve submission of forms to comply with the PCHQR Program requirements. Unlike other existing quality reporting programs, however, the PCHQR Program is not linked to any payment penalties if quality measures are not submitted.

The Office of Management and Budget (OMB) has approved the Program/Procedural Requirements forms including Notice of Participation (NOP), Data Accuracy and Completeness Acknowledgement (DACA), Measures Exception, Extraordinary Circumstances Exception (ECE), and measure data collection forms. Burden associated with measure data collection forms is accounted for by the PCHQR Program under OMB control number 0938-1175. Other forms are used across ten quality programs (Hospital IQR Program, Hospital Outpatient Quality Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Hospital VBP Program, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, End Stage Renal Disease Quality Incentive Program, and Skilled Nursing Facility Value-Based Purchasing Program); therefore we have included the burden associated with these forms under OMB control number 0938-1022 (Hospital IQR Program).

In the FY 2024 IPPS/LTCH PPS final rule, we are adopting four new measures into the PCHQR Program measure set: (1) the Documentation of Goals of Care Discussions Among Cancer Patients measure beginning with the FY 2026 program year, (2) the Facility Commitment to Health Equity measure beginning with the FY 2026 program year; (3) the Screening for Social Drivers of Health measure with voluntary reporting for the FY 2026 program year and mandatory reporting beginning with the FY 2027 program year; and (4) the Screen Positive Rate for Social Drivers of Health measure with voluntary reporting in the FY 2026 program year and mandatory reporting beginning with the FY 2027 program year. We note that as stated below in section 12, estimates for the PCHQR Program exclude burden associated with six National Healthcare Safety Network (NHSN) measures, which are submitted separately under OMB control number 0920-0666, and the Hospital Consumer Assessment of Healthcare Providers and

Systems (HCAHPS) measure, which is submitted separately under OMB control number 0938-0981.

The purpose of this PRA submission is to revise the currently approved information collection request. Specifically, we will modify the currently approved information collection request to reflect updated burden estimates, based on the FY 2024 IPPS/LTCH PPS final rule and an increase in the labor wage.

B. Justification

1. Need and Legal Basis

Section 1886(k)(1) of the Social Security Act states that, for FY 2014 and each subsequent fiscal year, each PCH shall submit data on quality measures as specified by the Secretary. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary. We continue to require PCHs to meet the procedures previously set forth for making public the data/measure rates submitted under the PCHQR Program.

2. Information Users

- PCHs: The main points of focus for PCHs are to examine their individual PCH-specific care domains and types of patients so they can compare present performance to past performance as well as to national performance norms; to evaluate the effectiveness of care provided to specific types of patients and, in the context of investigating processes of care, to individual patients; to monitor quality improvement outcomes continuously over time and assess their own strengths and weaknesses in the clinical services they provide objectively; and to inform the respective PCH of the care-related areas, activities, and/or behaviors that result in effective patient care, and alert them to needed improvements. Such information is essential to PCHs in initiating quality improvement strategies and can also be used to improve PCHs' resource planning.

- State Agencies/CMS: Agency profiles are used to compare a PCH's results with its peer performance. The availability of peer performance enables state agencies and CMS to identify opportunities for improvement in the PCH, and to evaluate more effectively the PCH's own quality assessment and performance improvement program.

- Accrediting Bodies: National accrediting organizations such as The Joint Commission (TJC) or state accreditation agencies may wish to use the information to target potential or identified problems during the organization's accreditation review of that facility.

- Beneficiaries/Consumers: In November 2014, the PCHQR Program began publicly reporting quality measures on the *Hospital Compare* website, now called *Care Compare*, available to consumers on www.Medicare.gov. On December 1, 2020, CMS relocated PCH data to the Provider Data Catalog (PDC). The PDC site can be accessed at https://data.cms.gov/provider-data/. The website provides information for

consumers and their families about the quality of care provided by an individual hospital, allowing them to see how well patients of one facility fare compared to those in other facilities and to state and national averages. Modeled after the Hospital IQR Program, the PCHQR Program uses quality measures to assist consumers in making informed decisions when choosing a PCH; to monitor the care the PCH is providing; and to stimulate the PCH to further improve quality and identify optimal practice.

3. Use of Information Technology

To assist hospitals in standardizing data collection initiatives across the industry, CMS continues to improve data collection tools in order to make data submission easier for hospitals (e.g., the collection of electronic patient data in EHRs for electronic clinical quality measures (eCQMs), the collection of data from paper medical records for chart-abstracted measures, or the collection of data from clinical registries for structural measures), as well as increase the utility of the data provided by the hospitals.

For claims-based measures, this section is not applicable, because claims-based measures are calculated based on data that are already reported to the Medicare program for payment purposes. Therefore, no additional information collection or information technology will be required of hospitals for these measures.

4. Duplication of Efforts

Where possible, we have selected measures that are currently reported through a common mechanism for all hospitals to conduct uniform measure reporting across settings. For example, we leverage data reported to the CDC through the NHSN so as not to require duplicate reporting.

5. Small Business

Information collection requirements were designed to allow maximum flexibility specifically to small PCH providers participating in the PCHQR Program. This effort assists small PCH providers in gathering information for their own quality improvement efforts. For example, we provide a help-desk hotline for troubleshooting purposes and 24/7 free information available on the QualityNet website through a Questions and Answers (Q&A) function.

6. Less Frequent Collection

We have designed the collection of quality of care data to be the minimum necessary for reporting of data on measures that are meaningful indicators of cancer patient care, and for calculation of summary figures to be used as reliable estimates of hospital performance. Data collection may vary (monthly, quarterly, annually, etc.) based on how an individual quality measure is specified.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

A 60-day *Federal Register* notice of the FY 2024 IPPS/LTCH PPS proposed rule (88 FR 26658) was published on May 1, 2023. We did not receive comments regarding the burden estimates included in this PRA package in the FY 2024 IPPS/LTCH PPS final rule (RIN 0938-AV08, CMS-1785-F), which published on August 28, 2023 (88 FR 58640).

CMS is supported in this initiative by The Joint Commission, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, and the consensus-based entity (CBE) described in section 1890 of the Social Security Act. These organizations collaborate with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making the information accessible, understandable, and relevant to the public.

9. Payment/Gift to Respondent

No payments or gifts will be given to respondents for participation.

10. Confidentiality

All information collected under this initiative is maintained in strict accordance with statutes and regulations governing confidentiality requirements for Quality Improvement Organizations, which can be found at 42 CFR Part 480. In addition, the tools used for transmission of data are considered confidential forms of communication and are Health Insurance Portability and Accountability Act (HIPAA)-compliant. The CMS clinical data warehouse also voluntarily meets or exceeds the HIPAA standards.

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimate (Total Hours & Wages)

a. Background

For the PCHQR Program, the burden associated with meeting program requirements includes the time and effort associated with completing administrative requirements and collecting and submitting data on the required measures for the 11 PCHs participating in the PCHQR Program.

We estimate a total annual burden of 0 hours and a total annual labor cost of $0 under OMB control number 0938-1175 across the 11 PCHs for data collection and submission for the FY 2025 program year. The 15 measures currently approved for the PCHQR measure set for the FY 2025 program year are shown in Table 1. We note that our estimates exclude burden associated with the six previously approved NHSN measures, which are submitted separately under OMB control number 0920-0666. Additionally, these estimates exclude the burden associated with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure,

which is submitted separately under OMB control number 0938-0981. We also exclude the burden associated with the COVID-19 Healthcare Personnel (HCP) Vaccination measure, for which data are submitted under OMB control number 0920-1317. Finally, we do not include burden associated with claims-based measures as these measures are calculated using claims data submitted by the PCHs as part of their reimbursement process and are calculated by CMS without additional information collection, not by the PCHs.

Table 1. Currently Approved PCHQR Measure Set for the FY 2025 Program Year

Measure name	**Measure Type**	**OMB Control #**
Central Line-Associated Bloodstream Infection Outcome Measure (CLABSI) (CBE# 0139) (PCH-4)	NHSN	0920-0666
Catheter-Associated Urinary Tract Infection Outcome Measure (CAUTI) (CBE #0138) (PCH-5)	NHSN	0920-0666
Harmonized Procedure Specific SSI Outcome Measure (CBE #0753) (PCH-6 [colon] and PCH-7 [hysterectomy])	NHSN	0920-0666
Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (CBE #1717) (PCH-26)	NHSN	0920-0666
Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (CBE #1716) (PCH-27)	NHSN	0920-0666
Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (CBE #0431) (PCH-28)	NHSN	0920-0666
Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (CBE #0210) (PCH-32)	Claims-based	0938-1175
Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (CBE #0215) (PCH-34)	Claims-based	0938-1175
Proportion of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (EOL-ICU) (CBE #0213) (PCH-33)	Claims-based	0938-1175
Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (CBE #0216) (PCH-35)	Claims-based	0938-1175
HCAHPS Survey (CBE #0166) (PCH-29)	Survey	0938-0981
Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (PCH-30 and PCH-31)	Claims-based	0938-1175
30-Day Unplanned Readmissions for Cancer Patients (CBE #3188) (PCH-36)	Claims-based	0938-1175
Surgical Treatment Complications for Localized Prostate Cancer (PCH-37)	Claims-based	0938-1175
COVID-19 Healthcare Personnel Vaccination	NHSN	0920-1317

b. Updated Hourly Wage Rate

According to the Bureau of Labor Statistics (BLS) rate, the median wage for Medical Records Specialists is $22.43 per hour[1] before inclusion of overhead and fringe benefits. The BLS describes Medical Records and Health Information Technicians as those responsible for compiling, processing, and maintaining medical records of hospital and clinic patients in a manner consistent with medical, administrative, ethical, legal, and regulatory requirements of the healthcare system; therefore, we believe it is reasonable to assume that these individuals would be tasked with submitting data for the PCHQR Program.

We estimate the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage, as is currently done in other CMS quality reporting programs. This is necessarily a rough adjustment, because fringe benefits and overhead costs vary significantly from employer to employer. Nonetheless, we believe that doubling the hourly wage rate ($22.43 x 2 = $44.86) to estimate total cost is a reasonably accurate estimation method. Accordingly, we will use an hourly labor cost estimate of $44.86 ($22.43 salary plus $22.43 fringe and overhead) for calculation of burden forthwith.

c. Burden Calculation for the Facility Commitment to Health Equity Structural Measure Beginning with the FY 2026 Program Year

In the FY 2024 IPPS/LTCH PPS final rule, we are adopting the Facility Commitment to Health Equity Structural Measure beginning with the FY 2026 program year. This measure is currently approved under OMB control number 0938-1022 for the Hospital IQR Program with an estimated burden of no more than 10 minutes per hospital per year, as it involves attesting to as many as five questions one time per year for a given reporting period.

PCHs will report data through the HQR System on an annual basis during the submission period. Using the estimate of 10 minutes (or 0.167 hours) per PCH per year, and the updated wage estimate as described previously, we estimate a total annual burden of approximately 2 hours across all PCHs (0.167 hours × 11 PCHs) at a cost of $90 (2 hours × $44.86).

d. Burden Calculation for the Documentation of Goals of Care Discussions Among Cancer Patients Measure Beginning with the FY 2026 Program Year

In the FY 2024 IPPS/LTCH PPS final rule, we are adopting the Documentation of Goals of Care Discussions Among Cancer Patients measure beginning with the FY 2026 program year. PCHs will report data through the Hospital Quality Reporting (HQR) System on annual basis during the submission period.

Similar to other measures reported via the HQR System for the PCHQR Program, we estimate a burden of no more than 10 minutes per hospital per year, as each hospital will only be required to report one aggregate numerator and denominator for all patients. Using the estimate of 10 minutes (or 0.167 hours) per PCH per year, and the updated wage estimate as described previously, we estimate a total annual burden of approximately 2 hours across all PCHs (0.167 hours × 11 PCHs) at a cost of $90 (2 hours × $44.86).

[1] U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed on January 13, 2023. Available at: https://www.bls.gov/oes/current/oes292072.htm.

e. Burden Calculation for the Screening for Social Drivers of Health Measure Beginning with the FY 2026 Program Year

In the FY 2024 IPPS/LTCH PPS final rule, we are adopting the Screening for Social Drivers of Health measure beginning with voluntary reporting in the FY 2026 program year followed by mandatory reporting on an annual basis beginning with the FY 2027 program year. This measure is currently approved under OMB control number 0938-1022 for the Hospital IQR Program with an estimated burden of 2 minutes (0.033 hours) per patient to conduct this screening and 10 minutes (0.167 hours) per hospital response to transmit the measure data.

PCHs will be able to collect data and report the measure via multiple methods. We believe that most PCHs will likely collect data through a screening tool incorporated into their electronic health record (EHR) or other patient intake process. For data submission, PCHs will report measure data through the HQR System annually.

For patients completing the survey, we believe that the cost for beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $20.71/hour. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices identifies the approach for valuing time when individuals undertake activities on their own time.[2] To derive the costs for beneficiaries, a measurement of the usual weekly earnings of wage and salary workers of $998, divided by 40 hours to calculate an hourly pre-tax wage rate of $24.95/hour. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in the post-tax hourly wage rate of $20.71/hour. Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

Based on the most recent patient data from PCHs, approximately 275 patients will be screened annually in each PCH for this measure, for a total of 3,025 patients across all 11 PCHs. If additional data regarding the number of patients screened annually is available in the future, we will update our estimate at that time. For the purposes of calculating burden for voluntary reporting in the FY 2026 program year, we assume 50 percent of PCHs will screen 50 percent of patients. For the FY 2027 program year, we assume 100 percent of PCHs will screen 100 percent of patients. For the FY 2026 program year, we estimate that 828 total patients will be screened (6 PCHs x 138 patients/PCH) for a total annual burden for patient screening of 28 hours (828 respondents x 0.033 hours) at a cost of $580 (28 hours x $20.71). For data submission for the FY 2026 program year, we estimate a burden of 1 hour (0.167 hours x 6 PCHs) at a cost of $45 (1 hour x $44.86). For the FY 2027 program year, we estimate a total annual burden for patient screening of 101 hours (3,025 respondents x 0.033 hours) at a cost of $2,092 (101 hours x $20.71) across all PCHs. For data submission for the FY 2027 program year, we estimate a total annual burden of approximately 2 hours across all PCHs (0.167 hours × 11 PCHs) at a cost of $90 (2 hours × $44.86).

[2] https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework

f. Burden Calculation for the Screen Positive Rate for Social Drivers of Health Measure Beginning with the FY 2026 Program Year

In the FY 2024 IPPS/LTCH PPS final rule, we are adopting the Screen Positive Rate for Social Drivers of Health measure with voluntary reporting with the FY 2026 program year and mandatory reporting beginning with the FY 2027 program year. This measure is currently approved under OMB control number 0938-1022 for the Hospital IQR Program with an estimated burden of 10 minutes (0.167 hours) per hospital response to transmit the measure data as we estimate only the additional burden for a hospital reporting via the HQR System since patients will not need to provide any additional information for this measure. For the purposes of calculating burden for voluntary reporting in the FY 2026 program year, we assume 50 percent of PCHs will transmit measure data. For the FY 2027 program year, we assume 100 percent of PCHs will transmit measure data.

We estimate a total burden in the FY 2026 program year of 1 hour (0.167 hours × 6 PCHs) at a cost of $45 (1 hours × $44.86/hour). We estimate a total annual burden beginning with the FY 2027 program year of 2 hours across all PCHs (0.167 hours × 11 PCHs) at a cost of $90 (2 hours × $44.86/hour).

g. Summary

We estimate a total hourly burden of 35 burden hours across the 11 PCHs for data collection and submission and a total annual labor cost for all 11 PCHs of $895 for the FY 2026 program year. We estimate a total hourly burden of 109 burden hours across the 11 PCHs for data collection and submission and a total annual labor cost for all 11 PCHs of $2,452 for the FY 2027 program year and subsequent years. A summary of the change in labor hours is reflected in Table 2 and a summary of change in cost is reflected in Table 3.

Table 2. Summary of Annual Burden Hour Estimates for the FY 2025 through FY 2027 Program Years

Measure	**FY 2025 Program Year**		**FY 2026 Program Year**		**FY 2027 Program Year and Subsequent Years**	
	Burden	+/- from Currently Approved	Burden	+/- from Currently Approved	Burden	+/- from Currently Approved
Facility Commitment to Health Equity Structural Measure	0	0	2	+2	2	+2
Adoption of the Documentation of Goals of Care Discussions Among Cancer Patients Measure	0	0	2	+2	2	+2
Screening for Social Drivers of Health Measure (Survey Completion)	0	0	28	+28	101	+101
Screening for Social Drivers of Health Measure (Reporting)	0	0	2	+2	2	+2
Screen Positive Rate for Social Drivers of Health	0	0	1	+1	2	+2

Measure						
TOTAL	**0**	**0**	**35**	**+35**	**109**	**+109**

Table 3. Summary of Annual Burden Cost Estimates for the FY 2025 through FY 2027 Program Years

Measure	**FY 2025 Program Year**		**FY 2026 Program Year**		**FY 2027 Program Year and Subsequent Years**	
	Burden	+/- from Currently Approved	Burden	+/- from Currently Approved	Burden	+/- from Currently Approved
Facility Commitment to Health Equity Structural Measure	0	0	$90	+$90	$90	+$90
Adoption of the Documentation of Goals of Care Discussions Among Cancer Patients Measure	0	0	$90	+$90	$90	+$90
Screening for Social Drivers of Health Measure (Survey Completion)	0	0	$580	+$580	$2,092	+$2,092
Screening for Social Drivers of Health Measure (Reporting)	0	0	$90	+$90	$90	+$90
Screen Positive Rate for Social Drivers of Health Measure	0	0	$45	+$45	$90	+$90
TOTAL	**0**	**0**	**$895**	**+$895**	**$2,452**	**+$2,452**

13. Capital Costs (Maintenance of Capital Costs)

Regarding the Facility Commitment to Health Equity measure, in order for PCHs to receive credit for all of the five domains in the measure, affirmative attestations are required for all of those domains. For PCHs that are unable to attest affirmatively for a domain, there are likely to be additional costs associated with activities which could include updating hospital policies, engaging senior leadership, participating in new quality improvement activities, performing additional data analysis, or training staff. The extent of these costs would vary from PCH to PCH depending on what activities the PCH is already performing, size, and the individual choices each PCH makes in order to meet the criteria necessary to attest affirmatively.

Regarding the Screening for Social Drivers of Health, for PCHs that are not currently administering some screening mechanism and elect to begin doing so as a result of this policy, there would be some non-recurring costs associated with changes in workflow and information systems to collect the data. The extent of these costs is difficult to quantify as different PCHs may utilize different modes of data collection (for example, paper-based, electronically patient-directed, clinician-facilitated, etc.). In addition, depending on the method of data collection utilized, the time required to complete the survey may add a negligible amount of time to patient visits.

14. Cost to Federal Government

The labor cost for government employees to support this program is estimated as one (1) FTE at a GS-13 step 5 salary = $126,949[3].

15. Program or Burden Changes

We previously estimated an annual burden of 0 hours and $0 cost for the 15 measures currently approved for the PCHQR program for the FY 2025 program year. For the four measures being finalized for the FY 2026 program year and subsequent years, we estimate a total burden increase of 109 hours at a cost of $2,452, including the impact of updated wage rates.

16. Publication/Tabulation Dates

The goal of the data collection is to tabulate and publish PCH-specific data. We will continue to display PCH quality information for public viewing as required by Social Security Act section 1866(k)(4) for the PCHQR Program. Hospital data from these initiatives are currently used to populate the Compare tool hosted by HHS, available at: https://www.medicare.gov/care-compare/, or its successor website(s). Data are presented on the Compare tool hosted by HHS in a format mainly aimed towards consumers, patients, and the general public, providing access to PCH-specific quality measure performance rates along with state and national performance rates. For certain quality measures, data are presented on the Compare tool hosted by HHS in performance categories of Better, No Different, or Worse than the National Rate. More detailed measure data, including the data used for the Compare tool hosted by HHS, are also available to the public as downloadable files at https://data.medicare.gov. PCH quality data on the Compare tool hosted by HHS are currently updated on a quarterly and annual basis.

17. Expiration Date

CMS will display the expiration date on all of the forms.

18. Certification Statement

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

[3] Office of Personnel Management. *2023 General Schedule.* Retrieved on March 14, 2023 from https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/23Tables/html/DCB.aspx