Supporting Statement—Part A

Submission of Information for the Hospital-Acquired Condition (HAC) Reduction Program (OMB #0938-1352, CMS-10668)

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 to achieve its overarching priorities and initiatives, including the Meaningful Measure 2.0 Initiative[1]. In particular, Meaningful Measures 2.0 promotes innovation and modernization of all aspects of quality to better address health care priorities and measurement gaps, reduce burden, and increase efficiency by: (1) using only high-value quality measures impacting key quality domains, (2) aligning measures across value-based 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.

The information collection requirements through the FY 2025 program year are currently approved under OMB control number 0938-1352 (expiration date November 30, 2027). This request covers data collection requirements for the FY 2026 program year and subsequent years.

B. Justification

1. Need and Legal Basis

The requirements of the HAC Reduction Program are set forth under section 1886(p) of the Social Security Act, which requires the Secretary to reduce payments to subsection (d) hospitals in the worst-performing quartile of all subsection (d) hospitals by 1 percent effective beginning on October 1, 2014 and subsequent years.

The HAC Reduction Program identifies the worst-performing quartile of hospitals by calculating a Total HAC Score derived from the CMS Patient Safety and Adverse Events Composite measure (CMS PSI 90) and the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Healthcare-associated infection (HAI) measures, which require that we collect claims-based and chart-abstracted measures data, respectively. The HAC Reduction Program validates NHSN HAI data reported by subsection (d) hospitals to ensure that hospitals report correct NHSN HAI measure data, and the Total HAC Score is calculated using accurate data. The HAC Reduction Program may penalize any hospitals that fail validation by assigning the maximum Winsorized *z*-score for the set of measures that fail validation, for use in the Total HAC

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

Score calculation. The collection of information for validation is necessary to ensure that the HAC Reduction Program and Total HAC Score are administered fairly.

(a) HAC Reduction Program Measures

The HAC Reduction Program must collect information to verify hospital exceptions and data submissions. 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. The HAC Reduction Program relies on data collection for HAI measures established through the CDC under OMB control number 0920-0666 (expiration date December 31, 2027), and validation processes established through the Hospital Inpatient Quality Reporting (IQR) Program under OMB control number 0938-1022 (expiration date January 31, 2026). However, in the FY 2019 IPPS/LTCH PPS final rule, the Hospital IQR Program finalized the removal of the CDC NHSN HAI measures and NHSN HAI validation processes beginning on January 1, 2020. To continue validation of these measures, the HAC Reduction Program adopted validation templates similar to the ones previously used under the Hospital IQR Program. These templates continue the HAC Reduction Program's use and validation of NHSN HAI data.

The HAC Reduction Program currently has adopted six measures finalized in previous rulemaking, shown in Table 1.

Table 1. Currently Approved HAC Reduction Program Measures for the FY 2026 Program Year

Measure Data Submission Mode and Name
Claims-Based Measures
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)
NHSN NAI Measures
CDC NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
CDC NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure
CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure
American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure

Because the burden associated with submitting data for the NHSN HAI measures shown in Table 1 is captured under OMB control number 0920-0666, we do not provide an independent estimate of the burden associated with collecting data for these measures for the HAC Reduction Program. We also do not provide an estimate of burden for the claims-based CMS PSI 90 measure, because this measure is collected using Medicare Fee-for-Service (FFS) claims that hospitals are already submitting to the Medicare program for payment purposes. Similarly, we do not provide an estimate of burden for validation of data submitted for the CMS PSI 90 measure, because Medicare claims are audited under the Medicare FFS Recovery Audit Program.

The FY 2026 program year for the HAC Reduction Program will be based on data for the CMS

PSI 90 measure using the 24-month period from July 1, 2022 through June 30, 2024, and data for NHSN HAI measures using the 24-month period from January 1, 2023 through December 31, 2024, which are consistent with the applicable periods specified at 42 CFR § 412.170. Because the HAC Reduction Program is a payment program, it must ensure proper exceptions are available to hospitals that do not meet NHSN HAI data requirements and to ensure the accuracy of the NHSN HAI data submissions.

(b) HAC Reduction Program Administrative Forms

CMS has implemented procedural requirements that align the current quality reporting programs, including the HAC Reduction, PPS-Cancer Hospital Quality Reporting (PCHQR), Hospital IQR, Hospital Readmissions Reduction, Hospital Outpatient Quality Reporting (OQR), and Hospital Value-Based Purchasing (VBP) Programs. These procedural requirements involve submission of forms to comply with the HAC Reduction Program requirements.

The HAC Reduction Program uses five administrative forms: (1) Data Accuracy and Completeness Acknowledgement (DACA) Form; (2) Measure Exception Form for NHSN HAI Data Submission; (3) Validation Educational Review Form; (4) Validation Review for Reconsideration Request Form; and (5) Extraordinary Circumstances Exceptions (ECE) Request Form. We discuss validation templates in section B.12.d. The DACA, Validation Educational Review Form, Validation Review for Reconsideration Request Form, and ECE Request Form are used across ten quality programs (Hospital IQR Program, Hospital OQR Program, Inpatient Psychiatric Facility Quality Reporting Program, PCHQR Program, Ambulatory Surgical Center Quality Reporting Program, Hospital VBP Program, HAC Reduction Program, Hospital Readmissions Reduction Program, End Stage Renal Disease Quality Incentive Program, and Skilled Nursing Facility VBP Program), therefore we have included the burden associated with these forms under OMB control number 0938-1022 (Hospital IQR Program). Most of these administrative forms are not completed on an annual basis, but on a need-to-use, exception basis, and most hospitals will not need to complete any of these forms in any given year. Thus, the burden for providers associated with forms utilized in the HAC Reduction Program is nominal, if any.

a. DACA Form

Annually, hospitals participating in hospital quality reporting use the Hospital Quality Reporting DACA form after the end of each reporting year. This requirement was added based on a U.S. Government Accountability Office report from 2006 that recommended that CMS require hospitals to "formally attest to the completeness of the quality data that they submit." This form, completed annually, is an acknowledgement that the data a hospital has submitted are complete and accurate.

b. Measure Exception Form for NHSN HAI Data Submission

Hospitals that do not treat specified conditions or that do not have treatment locations defined for certain NHSN's HAI measures (CLABSI, CAUTI, and Surgical Site Infection) have the option to either complete the enrollment process with NHSN and indicate that they do not have patients who meet the measure requirements or submit a Measure Exception Form for NHSN HAI Data

Submission. This Measure Exception Form reduces the burden of completing the entire NHSN enrollment process or entering zero denominator information for inapplicable measures for the hospitals that meet the exception requirements.

c. Validation Educational Review Form

Hospitals may use the educational review process to correct disputed chart-abstracted HAI-measure validation results. To submit a formal request, hospitals can utilize the Validation Educational Review Form. We note that should the results of an educational review not be favorable to a hospital, a hospital may still also request reconsideration of those results using the Validation Review for Reconsideration Request Form.

d. Validation Review for Reconsideration Request Form

If CMS determines that a hospital failed validation and the hospital would like to request a reconsideration, the hospital must complete and submit this form and if desired, may submit a copy of the entire medical record for the appealed element(s).

e. ECE Request Form

CMS offers a process for hospitals to request exceptions to the reporting of required data, for one or more quarters when a hospital experiences an extraordinary circumstance beyond the hospital's control. In the FY 2026 IPPS/LTCH PPS proposed rule, CMS is proposing to explicitly include *extensions* as a type of extraordinary circumstances relief option, in addition to exceptions, and that the ECE, Request Form must be submitted within 30 calendar days of an extraordinary circumstance event for all programs. 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.

2. Information Users

CMS will use the information collected for the HAC Reduction Program to determine whether a hospital is within the penalty quartile of subsection (d) hospitals. As stated above, the HAC Reduction Program applies a 1-percent payment reduction or penalty to subsection (d) hospitals in the worst-performing quartile of all subsection (d) hospitals. To determine which hospitals are in the worst-performing quartile, the HAC Reduction Program uses CMS PSI 90 data and NHSN HAI measure data. The Program must collect chart-abstracted information to validate NHSN HAI data reported by subsection (d) hospitals to ensure that hospitals report correct NHSN HAI measure data, and the Total HAC Score is calculated using accurate data. The information will be made available publicly and confidentially for hospitals to use in internal quality improvement initiatives.

Hospital measure information is also used by CMS to direct its contractors to focus on particular areas of improvement and to develop quality improvement initiatives. Quality Improvement Organizations (QIOs), under contract with CMS use safety measure data from CMS to assist communities in their quality improvement activities to, for example, reduce avoidable patient harms.

This information is also available to Medicare beneficiaries, as well as to the general public, by providing hospital information on the Compare tool hosted by HHS, currently available at: https://www.medicare.gov/care-compare, or its successor website(s) and the Provider Data Catalog available at cms.data.gov to assist them in making decisions about their healthcare. CMS sometimes conducts focus groups or market testing prior to publicly reporting hospital quality data on the Compare tool) 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 Comparetool.

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 the HAC Reduction Program and other CMS programs, CMS' findings were formally written into the latest triennial National Impact Assessment Report, which was released in CY 2024.[2]

3. Use of Information Technology

To assist hospitals 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 (including the collection of data from federal registries like the NHSN), and to increase the utility of the data provided by the hospitals. In addition, CMS has engaged a national support contractor to provide technical assistance with the data collection tool, other program requirements, and to provide education to support program participants.

For the claims-based measures, 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 hospitals 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 from hospitals.

5. Small Business

Information collection requirements are designed to allow maximum flexibility specifically to small hospitals wishing to participate in hospital reporting. This effort will assist small hospitals in gathering information for their own quality improvement efforts. We define a "small hospital" as one with 1-99 inpatient beds. Approximately 886 small subsection (d) hospitals were eligible to be selected for validation as part of the HAC Reduction Program in the FY 2025 program year. From the pool of 400 hospitals selected for validation as part of the HAC Reduction Program in the FY 2025 program year, approximately 142 were small subsection (d) hospitals. While these numbers may vary from year to year, we do not expect these numbers to change significantly for

[2] 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.

the FY 2026 program year.

No special processes or procedures are available to small hospitals to make the information collection less burdensome. We have previously finalized policies to make the processes under the HAC Reduction Program as similar as possible to the current Hospital IQR Program processes and anticipate that small hospitals participating in the Hospital IQR Program will continue to be familiar with the information collection request required for validation. 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 (Q&A) function.

6. Less Frequent Collection

CMS has designed the collection of quality-of-care data to be the minimum necessary for data validation and for calculation of summary figures to be used as reliable estimates of hospital performance. Data validation is expected to occur quarterly, but as noted above, only up to 400 hospitals will be selected for validation. Neither less frequent collection of data nor validation of fewer cases is practicable at this time. Less frequent data collection would strain the ability for CMS to validate the submitted validation template and associated NHSN HAI infection cases in a timely manner.

Under the current process, CMS Clinical Data Abstraction Center (CDAC) abstractors are able to review and validate hospital submissions as those submissions are made each quarter. If the hospitals submitted data less frequently, CDAC abstractors would not have time to complete the necessary reviews of each submission before the Total HAC Score is calculated. Similarly, if the HAC Reduction Program proposed to validate fewer cases, the statistical analysis would be altered, and the Program would be less likely to generate meaningful results from validation.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice for the FY 2026 IPPS/LTCH PPS proposed rule (RIN 0938-AV45, CMS-1833-P) was published on April 30, 2025 (90 FR 18002).

CMS is additionally supported in this program's efforts by the CDC, Health Resources and Services Administration, 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. Payments/Gifts to Respondents

No payments or gifts will be given to hospitals for participation. However, the HAC Reduction Program applies a 1-percent payment reduction or penalty to subsection (d) hospitals in the worst-performing quartile of all subsection (d) hospitals based on Total HAC score. The HAC Reduction

Program may also penalize any hospitals that fail validation by assigning the maximum Winsorized *z*-score for the set of measures that fail validation, for use in the Total HAC Score calculation.

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 HAC Reduction 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 hospital-specific data will be made publicly available as mandated by statute.

Data related to the HAC Reduction Program is housed in the Hospital Quality Reporting (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 HAC Reduction 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 information collections. 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, 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 Estimates (Hours & Wages)

(a) Background

In the FY 2026 IPPS/LTCH PPS proposed rule, we are not proposing to adopt new measures or remove any existing measures for the HAC Reduction Program.

(b) Burden for the FY 2026 Program Year

For the purposes of burden estimation, we assume all activities associated with the HAC Reduction Program for 3,050 IPPS hospitals, of which up to 400 will be selected for validation of the data submitted for the NHSN measures associated with the FY 2026 program year.

For the purposes of burden estimation, we assume all activities associated with the HAC Reduction Program will be completed by Medical Records Specialists. These staff are qualified to complete the tasks associated with the chart-abstraction of patient data from medical records, the submission of data to clinical registries, and the completion of any of the other applicable forms associated with activities related to the HAC Reduction Program.

OMB has currently approved burden of 28,840 hours at a cost of approximately $1,503,141 under OMB control number 0938-1352, accounting for information collection burden experienced by up to 400 hospitals selected for validation annually and up to 240 hospitals completing a Measure Exception form. As shown in Table 2, using updated wage rates, we estimate a revised baseline burden of 28,840 hours at a cost of $1,597,159 for the FY 2026 program year.

As previously discussed, this package excludes burden associated with the NHSN HAI data collection, which is captured under a separate OMB control number: 0920-0666. We also do not provide an estimate of burden for either the data collected or data validation associated with the claims-based CMS PSI 90 measure, because this measure is collected using Medicare FFS claims that hospitals are already submitting to the Medicare program for payment purposes and audited under the Medicare FFS Recovery Audit Program. We continue to include the burden associated with the DACA form, Validation Education Review Form, and ECE Request form under OMB control number 0938-1022 for the Hospital IQR Program. We note that as finalized in the FY 2011 IPPS/LTCH PPS final rule regarding information collection burden associated with the Hospital IQR Program's request for reconsideration process, information collection requirements imposed subsequent to an administrative action are not subject to the Paperwork Reduction Act (PRA) under 5 CFR 1320.4(a)(2), therefore, the time required for hospitals to complete the Validation Reconsideration Request for Review Form is not included in our estimate of burden (75 FR 50411).

Table 2. Currently Approved Burden Estimates for the HAC Reduction Program for the FY 2026 Program Year and Subsequent Years

Measure Set	***Estimated time per record (hours)***	***Number reporting quarters per year***	***Number of respondents***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Burden Hours***
HAI Validation Templates (CLABSI, CAUTI)	20	4	200	1	80	16,000
HAI Validation Templates (MRSA bacteremia, CDI)	16	4	200	1	64	12,800
Measure Exception Form	0.167	1	240	1	0.167	40
Total Burden Hours						**28,840**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)						**$1,597,159**

(c) Updated Hourly Wage Rate

While the most recent data from the BLS reflects a median hourly wage of $23.45 per hour for all medical records specialists, $27.69 is the mean hourly wage for "general medical and surgical hospitals," which is an industry within medical records specialists (we note that BLS does not provide median occupation wage rates for individual industries).[3] We believe the industry of "general medical and surgical hospitals" is more specific to our settings for use in our calculations than other industries that fall under medical records specialists, such as "office of physicians" or "nursing care facilities." We calculate the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage, consistent with previous years. This is necessarily 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 × 2 = $55.38) to estimate total cost is a reasonably accurate estimation method. Accordingly, we calculate cost burden to hospitals using a wage plus benefits estimate of $55.38 per hour for the HAC Reduction Program.

(d) Validation Template Submission Burden

The HAC Reduction Program is a payment program that assesses hospital performance with respect to healthcare safety of all subsection (d) hospitals using claims-based and NHSN HAI measures. While all claims-based data are submitted through claims processing systems that have validation methods to accept accurate Medicare claims into the claims database, the NHSN HAI data are not validated through other CMS processes. For the HAC Reduction Program to assess hospitals fairly, it must be able to ensure the accuracy of the data it collects. Validation is necessary to ensure the data used by the program are both correct and useful. To facilitate the HAC Reduction Program, validation templates for the CLABSI, CAUTI, MRSA bacteremia, and CDI measures are used to ensure data accuracy are necessary.

The validation templates are dependent upon a hospital's selection for validation and may not be required by any particular hospital in any given year. To validate NHSN HAI data, CMS performs a random selection of up to 200 subsection (d) hospitals and an additional 200 hospitals using targeting criteria on an annual basis for validation of chart-abstracted measures. Each hospital selected for validation is required to produce a list of patients or lab results associated with the measure being validated quarterly. All hospitals selected for validation will have their SSI measure data validated, but hospitals do not need to submit a template for this measure for CMS to select cases for validation. Approximately 200 hospitals will be required to produce the CLABSI and CAUTI templates and the other approximately 200 hospitals will be required to produce only the MRSA bacteremia and CDI templates.

We continue to estimate each hospital selected to produce the CLABSI and CAUTI validation templates will require 20 hours per quarter (80 hours annually) and each hospital selected to produce the MRSA bacteremia and CDI validation templates will require 16 hours per quarter (64 hours annually). We estimate a total burden of 28,800 hours [(80 hours per hospital to submit CLABSI and CAUTI templates x 200 hospitals) + (64 hours per hospital to submit MRSA bacteremia and CDI templates x 200 hospitals)] at a cost of $1,594,944 (28,800 hours x $55.38).

(e) Measure Exception Form Completion Burden

[3] Bureau of Labor Statistics, Occupational Employment and Wages. Accessed on February 3, 2025: https://www.bls.gov/oes/current/oes292072.htm.

We estimate the form will require 10 minutes (0.167 hours) to submit and based on data from previous years, assume 240 hospitals will complete the form annually. As a result, we estimate a total burden of 40 hours annually (0.167 hours x 240 hospitals) at a cost of $2,215 (40 hours x $55.38).

(f) Information Collection Instruments/Instructions

The validation templates for the CLABSI, CAUTI, MRSA bacteremia, and CDI measures are updated annually to reflect the annual changes in fiscal year and beginning reporting quarter, as well as new CDC pathogen lists, with each new selection of hospitals for validation. The templates for each year are only utilized by the hospitals that are selected for validation. We are submitting updated versions of the templates as well as the Measure Exception Form for NHSN HAI Data Submission and Validation Reconsideration Request for Review Form under OMB control number 0938-1352.

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs associated with the HAC Reduction Program's policies.

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 hospital and data vendors, calculation of claims-based measures and validation, measure development and maintenance, the provision of hospitals with feedback and preview reports, as well as costs associated with public reporting. These costs are estimated at $7,500,000 annually for the validation contract. Additionally, this program takes one and one-half (1.5) CMS staff at a GS-13 Step 5 level with approximate salaries of $136,658 plus benefits (30%) of $40,997 per staff member to operate for an additional cost of $266,483 (1.5 FTE x ($136,658 + $40,997)). The total annual cost to the Federal Government is $7,766,483.

For 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 FY 2025 program year of 28,840 hours at a total cost of $1,503,141. Accounting for updated wage rates, the total cost increases to $1,597,159 as shown in Table 2, a difference of $94,018.

While we are updating wage rates, we are not proposing any policies in the FY 2026 IPPS/LTCH PPS proposed rule which result in a change to our estimated burden.

16. Publication/Tabulation Dates

The goal of the data collection is to validate NHSN HAI data. We will continue to display quality information for public viewing on the Compare tool as required for the HAC Reduction Program by Section 1886(p)(6) of the Social Security Act. Data are presented on the Compare tool in a format mainly aimed towards consumers, patients, and the general public; providing access to hospital-specific quality measure performance rates along with state and national performance rates. Hospital quality data on the Compare tool are updated on a quarterly basis. One of the goals of the HAC Reduction Program is to publicly display data on all measures adopted for the Program. 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) HAC Reduction Program page. We will also display the approved expiration date prominently on our QualityNet website's HAC Reduction 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.