Supporting Statement - Part A

Submission of Information for the Medicare Promoting Interoperability Program: FY 2026 IPPS/LTCH PPS Proposed Rule (OMB# 0938-1278, CMS-10552)

A. Background

This is a revision of the currently approved information collection request. This information collection serves to implement the Health Information Technology for Economic and Clinical Health (HITECH) Act. We have developed objectives and measures to collect data and have the healthcare providers attest or report data as applicable to determine that they have met the requirements of the Medicare Promoting Interoperability Program. Eligible hospitals and Critical Access Hospitals (CAHs) must successfully demonstrate the meaningful use of certified electronic health record technology (CEHRT) under the Medicare Promoting Interoperability Program to avoid a downward payment adjustment.

Beginning in CY 2017, Medicare eligible professionals no longer reported to the Electronic Health Record (EHR) Incentive Program, as they began reporting under the Merit-based Incentive Payment System (MIPS) Promoting Interoperability Performance Category. With this separation, we began collecting data from eligible hospitals and CAHs to determine the application of the Medicare payment adjustments. This information collection was also used to make incentive payments to eligible hospitals in Puerto Rico from 2016 through 2021. In 2019, the EHR Incentive Program for eligible hospitals and CAHs was renamed the Medicare Promoting Interoperability Program. In subsequent years, we focused on balancing reporting burden for eligible hospitals and CAHs while also implementing changes designed to incentivize the advanced use of CEHRT to support health information exchange, interoperability, advanced quality measurement, and maximizing clinical effectiveness and efficiency.

The information collection requirements through the EHR reporting period in CY 2027 are currently approved under OMB control number 0938-1278 (expiration date April 30, 2027). This request covers data collection requirements for the EHR reporting period in CY 2026 and subsequent years. The revised information collection request accounts for the proposed adoption of a new optional bonus measure under the Public Health and Clinical Data Exchange objective and modifications to the Safety Assurance Factors for EHR Resilience (SAFER) Guides and Security Risk Analysis measures, as well as updated data and wage rates impacting previously approved burden calculations.

B. Justification

1. Need and Legal Basis

The American Recovery and Reinvestment Act of 2009 (Recovery Act) (Pub. L. 111-5) was enacted on February 17, 2009. Title IV of Division B of the Recovery Act amended Titles XVIII and XIX of the Social Security Act by establishing incentive payments to eligible professionals (EPs), eligible hospitals and CAHs, and Medicare Advantage (MA) organizations participating in the Medicare and Medicaid programs that adopt and

successfully demonstrate the meaningful use of CEHRT. These Recovery Act provisions, together with Title XIII of Division A of the Recovery Act, may be cited as the HITECH Act.

The HITECH Act created incentive programs for EPs, eligible hospitals and CAHs (under sections 1886(n) and 1814(l) of the Social Security Act), and MA organizations in the Medicare and Medicaid programs (under section 1853(m)(3) of the Social Security Act) that successfully demonstrated the meaningful use of CEHRT, which included reporting on electronic clinical quality measures (eCQMs). In accordance with the timeframe set forth in the statute, these incentive payments under Medicare are no longer available. The Act also allowed for negative payment adjustments in the Medicare FFS and MA programs starting in 2015 for EPs, eligible hospitals, CAHs, and MA organizations participating in Medicare that are not meaningful users of CEHRT. The last EHR reporting period that eligible hospitals in Puerto Rico could receive an incentive payment was in CY 2019 (FY 2021 payment year), and the EHR reporting period in CY 2020 (FY 2022 payment year) was the first year where they would be subject to a downward payment adjustment for failing to demonstrate meaningful use of CEHRT. The Medicaid Promoting Interoperability Program did not authorize downward payment adjustments, but its participants were eligible for incentive payments until December 31, 2021, when the program ended.

(a) Medicare Promoting Interoperability Program Measures and Attestations

For the EHR reporting period in CY 2026 and subsequent years, eligible hospitals and CAHs are required to report data for or attest to the measures and attestations shown in Table 1, as applicable, annually via an online submission form.

Table 1: Currently Approved Medicare Promoting Interoperability Program Measures and Attestations for the EHR Reporting Period in CY 2026 and Subsequent Years

Objective	Measure
N/A	ONC Direct Review
N/A	Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT
Protect Patient Health Information	Security Risk Analysis
	SAFER Guides
Electronic Prescribing	e-Prescribing
	Query of Prescription Drug Monitoring Program (PDMP)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information

Objective	Measure
	Support Electronic Referral Loops by Receiving and Reconciling Health Information
	OR
	Health Information Exchange (HIE) Bi-Directional Exchange
	OR
	Enabling Information Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) measure
	AND
	Electronic Prior Authorization measure*
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information
Public Health and Clinical Data Exchange	Report the following 6 measures: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Laboratory Reporting** • Antimicrobial Use (AU) Surveillance Measure • Antimicrobial Resistance (AR) Surveillance Measure
	Submit Level of Active Engagement
	Report one of the following measures (BONUS): • Public Heath Registry Reporting • Clinical Data Registry Reporting

* Required beginning with the EHR reporting period in CY 2027

**In prior rulemaking, we inadvertently referenced the measure name incorrectly. To ensure accuracy, we are correcting the measure's name to Electronic Laboratory Reporting measure. This is a non-substantive change and does not impact the measure's specifications or reporting requirements.

In addition, eligible hospitals and CAHs are required to report data for eCQMs annually. For eCQMs, information is electronically extracted from EHRs and/or health information technology (HIT) systems. Because patient data are already entered into EHRs and HITs as part of clinical practice, only the time associated with electronically submitting data to CMS is accounted for in our burden estimates as part of the Hospital Inpatient Quality Reporting (IQR) Program under OMB control number 0938-1022 (expiration date April 30, 2027). The currently approved eCQMs for the CY 2026 reporting period are shown in Table 2.

Table 2. Currently Approved Medicare Promoting Interoperability Program eCQMs

for the CY 2026 Reporting Period and Subsequent Years

Short Name	Measure Name
Safe Use of Opioids**	Safe Use of Opioids – Concurrent Prescribing
PC-02**	Cesarean Birth
PC-07**	Severe Obstetric Complications
STK-2	Discharged on Antithrombotic Therapy
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter
STK-5	Antithrombotic Therapy by End of Hospital Day Two
VTE-1	Venous Thromboembolism Prophylaxis
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis
HH-HYPO**	Hospital Harm - Severe Hypoglycemia
HH-HYPER**	Hospital Harm - Severe Hyperglycemia
HH-OREA**	Hospital Harm - Opioid-Related Adverse Events
HH-PI***	Hospital Harm - Pressure Injury
HH-AKI ***	Hospital Harm - Acute Kidney Injury
HH-FI	Hospital Harm – Falls With Injury
HH-RF	Hospital Harm - Postoperative Respiratory Failure
MCS*	Malnutrition Composite Score
IP-ExRad	Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient)

* The eCQM previously named Global Malnutrition Composite Score has been updated to Malnutrition Composite Score. The short name has subsequently been updated to MCS eCQM. This is a non-substantive change and does not impact the measure's specifications or reporting requirements.
** Signifies a required measure for the CY 2026 reporting period and subsequent years
*** Signifies a required measure added for the CY 2027 reporting period and subsequent years

(b) Summary of Proposed Medicare Promoting Interoperability Program Changes

In the FY 2026 IPPS/LTCH PPS proposed rule, we proposed to adopt a new optional bonus measure under the Public Health and Clinical Data Exchange objective for health information exchange with a public health agency (PHA) that occurs using TEFCA, and where the eligible hospital or CAH meets certain additional requirements, beginning with the EHR reporting period in CY 2026. We also proposed to modify two measures: (1) the SAFER Guides measure, which we proposed to modify by requiring eligible hospitals and CAHs to attest "yes" to completing an annual self-assessment using the SAFER Guides published in January 2025 beginning with the EHR reporting period in CY 2026; and (2) the Security Risk Analysis measure, which we proposed to modify to require eligible hospitals and CAHs to attest "yes" to having conducted security risk management as required under the HIPAA Security Rule beginning with the EHR reporting period in CY 2026. We also proposed to define the EHR reporting period in CY 2026 and subsequent years as a minimum of any continuous 180-day period within that CY for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program. We do not think any of these policies in the FY 2026 IPPS/LTCH PPS proposed rule would change information collection burden under OMB control number 0938-1278, as discussed further in section 12.

(c) Medicare Promoting Interoperability Program Forms

The Medicare Promoting Interoperability Program allows eligible hospitals and CAHs to apply for a Hardship Exception and avoid a downward payment adjustment in circumstances out of the hospital's control that make it difficult to meet program requirements. To be considered for an exception, eligible hospitals and CAHs must complete and submit a Hardship Exception application. If approved, the Hardship Exception is valid for only one payment adjustment year. Eligible hospitals and CAHs would need to submit a new application for subsequent years and no eligible hospital or CAH can be granted more than five exceptions, per section 1886(b)(3)(B)(ix)(II) of the Social Security Act. Hospitals may cite one of the following specified reasons for review and approval: (1) using decertified EHR technology, (2) insufficient internet connectivity; or (3) extreme and uncontrollable circumstances. The Hardship Exception form is only available electronically at https://cmsqualitysupport.servicenowservices.com/cms_hh.

2. Information Users

The data collected under this information collection request is used to validate compliance with the requirements for being a successful meaningful user of CEHRT under the Medicare Promoting Interoperability Program. Participants attest or report data as applicable to the required objectives and measures to meet the required threshold for being considered a meaningful user. They must also electronically submit measure data for eCQMs. If it is determined that the participant is a not a meaningful user of CEHRT, they would be subject to a downward payment adjustment. The collection of information burden analysis in the FY 2026 IPPS/LTCH PPS proposed rule focuses on eligible hospitals and CAHs that report on the objectives, measures, and eCQMs under the Medicare Promoting Interoperability Program.

We use the information collected from measure submissions to gain a better understanding of how eligible hospitals and CAHs are utilizing CEHRT and its functionality. We use the information collected from eCQM data to determine its impact on care delivery for Medicare beneficiaries. Our goal is to continue to advance the meaningful use of CEHRT with our priority to continue promoting interoperability through health information exchange among various health systems' EHRs.

Certain 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, and the Provider Data Catalog, currently available at: https://www.data.cms.gov, or their successor websites, 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 *Compare* tool hosted by HHS or its successor website(s).

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 eCQM data from the Medicare Promoting Interoperability Program and other CMS programs, CMS' findings were formally written

into the latest triennial National Impact Assessment Report, which was released in CY 2024.[1]

3. Use of Information Technology

To assist eligible hospitals and CAHs 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 (e.g., the automated collection of electronic patient data in EHRs for eCQMs), and to increase the utility of the data provided by participants. CMS also provides a secure data warehouse via CMS' Hospital Quality Reporting (HQR) system for storage and transmittal of data. Participants have the option of using 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.

Attestation and data reporting are completed on an annual basis via an online submission form. Outside of this online attestation and the Hardship Exception application described above, there are no physical nor additional forms used. Developers and CMS commonly refer to this program-specific format as the Attestation Screens, which are only open for completion by eligible hospitals and CAHs between January 1 and February 28 (referred to as the submission period).

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect data from eligible hospitals or CAHs. We prioritize efforts to reduce reporting burden for the collection of information by utilizing electronic data to the extent possible, as well as aligning eCQMs and related reporting requirements for eligible hospitals and CAHs with the Hospital IQR Program.

5. Small Businesses

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. The Medicare Promoting Interoperability Program included approximately 901 eligible hospitals for the EHR reporting period in CY 2023 that meet the definition of "small". In addition, as defined under 42 CFR Part 485 subpart F, a CAH may have no more than 25 inpatient beds and therefore, we assume all 1,400 CAHs would qualify as small hospitals. As a result, we estimate a total of 2,301 small hospitals (901 eligible hospitals + 1,400 CAHs) will submit data for the Medicare Promoting Interoperability Program for the EHR reporting period in CY 2026.

6. Less Frequent Collection

[1] 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 Health Services & Resources Administration's Medicare Rural Hospital Flexibility Program (Flex) and Medicare Beneficiary Quality Improvement Project, as well as CMS' Quality Improvement Organizations, 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.

CMS has designed the collection of information under the Medicare Promoting Interoperability Program to be the minimum necessary for eligible hospitals and CAHs to demonstrate the meaningful use of CEHRT. To implement the meaningful use provisions of the HITECH Act under the Medicare Promoting Interoperability Program, eligible hospitals and CAHs are required to attest to the identification of the CEHRT used (CEHRT ID), satisfaction of the applicable objectives and measures, and electronic reporting of clinical quality measures annually. Less frequent information collection would impede efforts to establish compliance with the HITECH Act.

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).

9. Payment/Gift to Respondent

No gifts will be given to respondents for participation. The program had previously utilized incentive payments to Medicare and Medicaid providers who successfully demonstrated meaningful use, however, these positive incentive adjustments ended in CY 2021.

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 Medicare Promoting Interoperability 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. The data collected will be for CMS internal use only and will not be published, except as finalized for public display under section 1886(n)(4)(B) of the Social Security Act, which requires the Secretary to post on the CMS website, in an easily understandable format, a list of the names of the eligible hospitals and CAHs that are

meaningful EHR users, and other relevant data as determined appropriate by the Secretary.

Data related to the Medicare Promoting Interoperability 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 Medicare Promoting Interoperability 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.

12. Burden Estimate (Total Hours and Wages)

(a) Background

In section B.1.b., we describe the proposals for the Medicare Promoting Interoperability Program for eligible hospitals and CAHs in the FY 2026 IPPS/LTCH PPS proposed rule.

In the FY 2026 IPPS/LTCH PPS proposed rule, we are proposed to define the EHR reporting period in CY 2026 and subsequent years as a minimum of any continuous 180-day period within that CY for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program. As this is the current requirement for the EHR reporting period in CY 2025 as finalized in the FY 2024 IPPS/LTCH PPS final rule (88 FR 59259 through 59260), this proposal would not result in any changes to the information collection burden currently approved under this OMB control number.

(b) Burden for the EHR Reporting Period in FY 2026

Based on data from the EHR reporting period in CY 2024, we are maintaining our estimate of approximately 3,150 eligible hospitals and 1,400 CAHs that will report data to the Medicare Promoting Interoperability Program for the EHR reporting period in CY 2026 and subsequent years, for a total number of 4,550 respondents.

OMB has currently approved burden of 30,151 hours at a cost of $1,571,474 under OMB control number 0938-1278, accounting for information collection burden experienced by approximately 3,150 eligible hospitals and 1,400 CAHs for the EHR reporting period in CY 2025. As shown in Table 3, we continue to estimate a total burden of 30,151 hours with an updated cost of $1,669,707 for the EHR reporting period in CY 2026; this reflects no change in hours and an increase of $98,233 due to updated wage rates. As previously stated, our burden estimates exclude burden associated with eCQM reporting for eligible hospitals and CAHs which is accounted for in our burden estimates as part of the Hospital IQR Program under OMB control number 0938-1022 (expiration date April 30, 2027).

Table 3: Currently Approved Burden Estimates for the Medicare Promoting

Interoperability Program for the EHR Reporting Period in CY 2025

Objective/Measure	*Estimated Time per Eligible Hospital/CAH (minutes)*	*Frequency of reporting per year*	*Number of eligible hospitals/ CAHs*	*Number records per hospital per quarter*	*Total Burden Hours for EHR Reporting Period in CY 2025*
Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT attestation	1	1	4,550	1	76
ONC Direct Review attestation	1	1	4,550	1	76
PROTECT PATIENT HEALTH INFORMATION					
Security Risk Analysis Measure	360	1	4,550	1	27,300
SAFER Guides Measure	1	1	4,550	1	76
ELECTRONIC PRESCRIBING					
e-Prescribing Measure	10	1	4,550	1	758
Query of PDMP Measure	0.5	1	4,550	1	38
HEALTH INFORMATION EXCHANGE					
Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures OR HIE Bi-Directional Exchange Measure OR Enabling Information Exchange Under the TEFCA Measure	10	1	4,550	1	758
Electronic Prior Authorization Measure*	0	1	4,550	1	0
PROVIDER TO PATIENT EXCHANGE					
Provide Patients Electronic Access to Their Health Information Measure	10	1	4,550	1	758
PUBLIC HEALTH AND CLINICAL DATA EXCHANGE					
Syndromic Surveillance Reporting Measure	0.5	1	4,550	1	38
Immunization Registry Reporting Measure	0.5	1	4,550	1	38
Electronic Case Reporting Measure	0.5	1	4,550	1	38
Electronic Laboratory Reporting	0.5	1	4,550	1	38

Measure**					
AU Surveillance Measure	0.5	1	4,550	1	38
AR Surveillance Measure	0.5	1	4,550	1	38
Submit Level of Active Engagement	0.5	1	4,550	1	38
Bonus Measures: Public Heath Registry Reporting Measure OR Clinical Data Registry Reporting Measure OR Public Health Reporting Using TEFCA Measure***	0.5	1	4,550	1	38
Hardship Exception applications	1	1	400	1	7
Total Burden Hours					**30,151**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)					**$1,669,707**

* The Electronic Prior Authorization measure will be required beginning with the EHR Reporting Period in CY 2027. At that time, the burden per eligible hospital and CAH will be 0.5 minutes.
**In prior rulemaking, we inadvertently referenced the measure name incorrectly. To ensure accuracy, we are correcting the measure's name to Electronic Laboratory Reporting measure. This is a non-substantive change and does not impact the measure's specifications or reporting requirements.
*** The Public Health Reporting Using TEFCA measure will be available for eligible hospitals and CAHs to report as an optional bonus measure beginning with the EHR Reporting Period in CY 2026, if finalized.

(c) Updated Hourly Wage Rate

Using the most recent data from the BLS for medical records specialists (SOC 29-2072), entitled, the May 2023 National Occupational Employment and Wage Estimates (OEWS), we propose to use the mean hourly wage for medical records specialists for the industry, "general medical and surgical hospitals," which is $27.69.[2] 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 Medicare Promoting Interoperability Program.

(d) Attestations not associated with an Objective

Eligible hospitals and CAHs are required to report on the Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT attestation as required by section 1886(n)(3)

[2] U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed March 11, 2025. Available at: https://www.bls.gov/oes/current/oes292072.htm.

(A)(ii) of the Social Security Act and the ONC Direct Review attestation to be considered a meaningful EHR user. As attestations, eligible hospitals and CAHs are required to report a "yes" or "no" response for each attestation. We continue to estimate an information collection burden for each eligible hospital and CAH of 1 minute to report each attestation. We therefore estimate a total burden for these attestations of 152 hours (0.0167 hours × 4,550 eligible hospitals and CAHs x 2 attestations) annually at a cost of $8,418 (152 hours x $55.38).

(e) Protect Patient Health Information Objective Reporting and Submission Burden

As shown in Table 3, under the Protect Patient Health Information Objective, eligible hospitals and CAHs are required to conduct or review a security risk analysis including addressing the security (to include encryption) of data created or maintained by CEHRT, implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process. Eligible hospitals and CAHs are also required to complete an annual self-assessment on each of the nine SAFER Guides at any point during the calendar year in which their EHR reporting period occurs. Eligible hospitals and CAHs must then submit "yes" attestations for both the Security Risk Analysis and SAFER Guides reporting measures to be considered a meaningful user.

In the FY 2026 IPPS/LTCH PPS proposed rule, we proposed to modify the SAFER Guides measure by requiring eligible hospitals and CAHs to attest "yes" to completing an annual self-assessment using the SAFER Guides published in January 2025 beginning with the EHR reporting period in CY 2026. Because we are not proposing an additional attestation, but instead propose to modify one that was previously finalized, this proposal would not result in any changes to the information collection burden. We continue to estimate it will require eligible hospitals and CAHs approximately 1 minute to attest to the SAFER Guides reporting measure annually.

In the FY 2026 IPPS/LTCH PPS proposed rule, we proposed to modify the Security Risk Analysis measure by requiring eligible hospitals and CAHs to attest "yes" to having conducted security risk management along with the security risk analysis as required under the HIPAA Security Rule, beginning with the EHR reporting period in CY 2026. The currently approved burden estimate for eligible hospitals and CAHs to conduct or review a security risk analysis, including addressing the security (to include encryption) of data created or maintained by CEHRT, implementing security updates as necessary, and correcting identified security deficiencies as part of the eligible hospital's or CAH's risk management process is approximately 6 hours annually. Given the negligible additional effort associated with this proposal compared to the currently approved burden estimate, we proposed that the currently approved burden estimate is sufficient to include the proposed attestation and did not propose any changes to the information collection burden.

We continue estimate a total burden for this Objective for each hospital of 361 minutes (6.0167 hours) to successfully meet the requirements of this Objective. We estimate a total burden for this Objective for all eligible hospitals and CAHs of 27,376 hours

(6.0167 hours × 4,550 eligible hospitals and CAHs) annually at a cost of $1,516,083 (27,376 hours x $55.38).

(f) Electronic Prescribing Objective Reporting and Submission Burden

As shown in Table 3, for the Electronic Prescribing Objective, eligible hospitals and CAHs are required to report both the Electronic Prescribing and Query of PDMP measures. We continue to estimate that eligible hospitals and CAHs will require 10 minutes to report the Electronic Prescribing measure and 0.5 minutes to report the Query of PDMP measure for a total of 10.5 minutes (0.175 hours) to report both measures. We estimate a total burden for this Objective of 796 hours across all eligible hospitals and CAHs (0.175 hours × 4,550 eligible hospitals and CAHs) annually at a cost of $44,082 (796 hours x $55.38).

(g) Health Information Exchange Objective Reporting and Submission Burden

As shown in Table 3, for the Health Information Exchange Objective, eligible hospitals and CAHs are required to report one of three alternatives: (1) the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures; (2) the HIE Bi-Directional Exchange measure; or (3) the Enabling Exchange Under the TEFCA measure. We continue to estimate eligible hospitals and CAHs will require 10 minutes (0.167 hours) to report one of the three alternatives.

In the Advancing Interoperability and Improving Prior Authorization Processes for MA Organizations and Medicaid Managed Care Plans, State Medicaid Agencies, State CHIP Agencies, CHIP Managed Care Entities, and Issuers of QHPs in the Federally-Facilitated Exchanges Final Rule published on February 8, 2024 (89 FR 8758), we finalized the Electronic Prior Authorization measure beginning with the EHR reporting period in CY 2027. As an attestation measure, eligible hospitals and CAHs are required to report a "yes" or "no" response. We continue to estimate eligible hospitals and CAHs will require 0.5 minutes (0.0083 hours) to report this measure.

In aggregate, for the EHR reporting period in CY 2026, we estimate a total burden for this Objective across all eligible hospitals and CAHs of 758 hours (0.167 hours x 4,550 hospitals) at a cost of $41,978 (758 hours x $55.38). Beginning with the EHR reporting period in CY 2027, we estimate a total burden for this Objective across all eligible hospitals and CAHs of 796 hours (0.175 hours x 4,550 hospitals) at a cost of $44,082 (796 hours x $55.38).

(h) Provider to Patient Exchange Objective Reporting and Submission Burden

As shown in Table 3, we continue to estimate eligible hospitals and CAHs will require 10 minutes (0.167 hours) to report the Provide Patients Electronic Access to Their Health Information measure. Therefore, we estimate a total information collection burden for this Objective of 758 hours (0.167 hours x 4,550 hospitals) at a cost of $41,978 (758

hours x $55.38).

(i) Public Health and Clinical Data Exchange Objective Reporting and Submission Burden

As shown in Table 3, for the Public Health and Clinical Data Exchange Objective, eligible hospitals and CAHs are required to attest to their level of active engagement for the measures under this Objective, either Pre-production and Validation or Validated Data Production. Eligible hospitals and CAHs must also attest to six measures: (1) the Syndromic Surveillance Reporting Measure, (2) the Immunization Registry Reporting Measure, (3) the Electronic Case Reporting Measure, (4) the Electronic Laboratory Reporting Measure, (5) the AU Surveillance Measure; and (6) the AR Surveillance Measure. In addition, eligible hospitals and CAHs may attest to one of the optional bonus Public Heath Registry Reporting or Clinical Data Registry Reporting measures.

In the FY 2026 IPPS/LTCH PPS proposed rule, we proposed to adopt a new optional bonus measure under the Public Health and Clinical Data Exchange objective for reporting data to a PHA under TEFCA, and where the eligible hospital or CAH meets certain additional requirements, beginning with the EHR reporting period in CY 2026. While eligible hospitals and CAHs can attest to more than one optional bonus measure, we assume they will not attest to more than one because they cannot receive any additional credit for doing so. Therefore, we are not making any changes to the currently approved information collection burden.

We estimate the burden associated with each of the eight attestations required under this Objective to be 0.5 minutes/measure for a total of 4 minutes (0.0667 hours) in aggregate (0.5 minutes x 8 attestations). Across all eligible hospitals and CAHs, we estimate a total annual burden of 303 hours (0.0667 hours x 4,550 hospitals) at a cost of $16,780 (303 hours x $55.38).

We note that under the AU and AR Surveillance Measures, while eligible hospitals and CAHs are required to attest to active engagement with CDC's National Healthcare Safety Network (NHSN) to submit AU and AR data, and receive a report from NHSN indicating their successful submission of AU and AR data for the EHR reporting period, the burden associated with the actual submission of AU and AR data to NHSN is accounted for under OMB control number 0920-0666.

(j) eCQM Measure Reporting and Submission Requirements

For the CY 2026 reporting period, eligible hospitals and CAHs are required to submit data for eight total eCQMs: three self-selected eCQMs, and the Safe Use of Opioids, Severe Obstetric Complications, Cesarean Birth Rate, Hospital Harm – Severe Hypoglycemia, and Hospital Harm – Severe Hyperglycemia eCQMs. For the CY 2027 reporting period, CAHs are required to submit data for these eight eCQMs in addition to the Hospital Harm – Opioid-Related Adverse Events eCQM. Lastly, for the CY 2028 reporting period and subsequent years, CAHs are required to submit data for these nine eCQMs as well as the Hospital Harm – Pressure Injury and Hospital Harm – Acute Kidney Injury eCQMs for a total of 11 eCQMs.

We continue to estimate the information collection burden associated with the eCQM reporting and submission requirements to be 10 minutes per measure per quarter. The burden associated with the reporting of eCQM measures for eligible hospitals and CAHs are accounted for under OMB control number 0938-1022.

(k) Hardship Exception

As discussed in section B.1.(c), eligible hospitals and CAHs may apply electronically for a Hardship Exception and avoid a downward payment adjustment in circumstances out of the hospital's control that make it difficult to meet program requirements. Based on the number of Hardship Exception applications received in prior EHR reporting periods, we estimate approximately 400 eligible hospitals and CAHs will apply annually and estimate the application requires approximately 1 minute (0.0167 hours) to complete. Therefore, we estimate an annual information collection burden of 7 hours (0.0167 hours x 400 applications) at a cost of $388 (7 hours x $55.38).

(l) Burden Estimate Summary

As shown in Table 4, in summary, under OMB control number 0938-1278, we estimate no change in information collection burden hours associated with our proposed policies (which also reflects use of updated hourly wage rates as previously discussed), from the EHR reporting period in CY 2026 through the EHR reporting period in CY 2027 and subsequent years, compared to our currently approved information collection burden estimates. The table below summarizes the total burden changes for each respective EHR reporting period compared to our currently approved information collection burden estimates.

Table 4. Summary of Annual Burden Estimates for the EHR Reporting Periods in CY 2026 through CY 2027 and Subsequent Years

Objective	EHR Reporting Period in CY 2026	Difference From Currently Approved	EHR Reporting Period in CY 2027 and Subsequent Years	Difference From Currently Approved
Attestations not associated with an Objective	152	0	152	0
Protecting Patient Health Information	27,376	0	27,376	0
Electronic Prescribing	796	0	796	0
Health Information Exchange	758	0	796	0
Provider to Patient Exchange	758	0	758	0
Public Health and Clinician Data Exchange	303	0	303	0
Hardship Exception	7	0	7	0
Total Burden Hour Estimate*	**30,151**	**0**	**30,188**	**0**
Total Burden Cost Estimate*	**$1,669,707**	**+$0**	**$1,671,811**	**+$0**

*Sum of individual Objective estimates may vary from annual totals due to rounding

These burden estimates exclude burden associated with the reporting of eCQMs for

eligible hospitals and CAHs under OMB control number 0938-1022, as Medicare hospitals report the data to CMS once per year for credit under both the Hospital IQR Program and the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

(m) Information Collection Instruments/Instructions

As discussed in section B.3, attestation and data reporting are completed on an annual basis via an online submission form commonly referred to by developers and CMS as the Attestation Screens. Outside of this online attestation, there are no physical nor additional forms used. We will submit screenshots of the revised Attestation Screens with this PRA package.

13. Capital Costs (Maintenance of Capital Costs)

In order to attest to the AU Surveillance and AR Surveillance measures successfully, an eligible hospital or CAH must be in active engagement with CDC's NHSN to submit AU and AR data and receive a report from NHSN indicating their successful submission of AU and AR data for the EHR reporting period. We previously discussed in our currently approved PRA application that participation in NHSN's surveillance requires the use of an AUR reporting solution. We estimate the annual cost for commercial software and equipment for use by hospital personnel to range between $59,100 and $146,500 annually, with a median of $70,900.[3] We believe these associated costs are outweighed by the more than $4.6 billion in health care costs spent annually treating antibiotic resistance threats.[4]

14. Cost to the Federal Government

The cost to the Federal Government for maintaining multiple hospital quality reporting 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, 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 $10,050,000 annually for the validation and quality reporting contracts. Additionally, this program takes three CMS staff at a GS-13 Step 5 level with approximate annual salaries of $136,658 plus benefits (30%) of $40,997 per staff member to operate for an additional cost of $532,965. The total annual cost to the Federal Government is $10,582,965.

15. Program or Burden Changes

We previously requested and received approval for total annual burden estimates under this OMB control number for the EHR reporting period in CY 2025 of 30,151 hours at a total cost of $1,571,474 as a result of policies finalized in the FY 2025 IPPS/LTCH PPS final rule. Accounting for updated wage rates, the total cost of $1,571,474 increases to $1,669,707 (an increase of $98,233 from our currently approved estimate). As discussed

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5051263/

[4] https://www.cdc.gov/drugresistance/solutions-initiative/stories/partnership-estimates-healthcare-cost.html

above, none of proposed updates in the FY 2026 IPPS/LTCH PPS proposed rule would change information collection burden under OMB control number 0938-1278.

16. Publication/Tabulation Dates

We will continue to display hospital information for public viewing as required by Social Security Act section 1886(n)(4)(B) for the Medicare Promoting Interoperability Program. Hospital data from the Medicare Promoting Interoperability Program is currently used to populate the *Compare* tool and the Provider Data Catalog. Data are presented on the *Compare* tool hosted by HHS in a format mainly aimed towards consumers, patients, and the public, providing access to overall scoring and performance data on eligible hospitals and CAHs. We note that in certain circumstances we may decide to delay public display as we evaluate the accuracy of the measure data.

17. Expiration Date

With the exception of the online form used for submitting attestations and Hardship Exception application which will display the approved expiration date, there are no additional forms associated with the Medicare Promoting Interoperability Program. We will also display the approved expiration date prominently on the Medicare Promoting Interoperability Program pages on CMS.gov 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.

B. Collection of Information Employing Statistical Methods

The use of statistical methods does not apply to this form.