U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFFICE OF MANAGEMENT AND BUDGET
PAPERWORK REDUCTION ACT
CLEARANCE PACKAGE

SUPPORTING STATEMENT-PART A

REQUEST FOR NEW INFORMATION COLLECTION REQUEST FOR ADMINISTRATIVE PROCEDURES FOR CHRONIC AND POST-ACUTE CARE QUALITY PROGRAMS

Supporting Statement – Part A

Administrative Procedures for Chronic and Post-Acute Care Quality Programs (OMB# 0938-NEW, CMS-10945

A. Background

This is a request for a new information collection. The Centers for Medicare & Medicaid Services' (CMS') quality reporting programs (QRPs) and value-based purchasing (VBP) 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 providers to make continued quality improvements.

Specifically, CMS has implemented QRPs for multiple settings, including for the home health (HH), hospice, inpatient rehabilitation facility (IRF), long-term acute care hospital (LTCH), and skilled nursing facility (SNF) settings, to achieve its overarching priorities and initiatives. Any Hospice, HH Agency (HHA), IRF, LTCH, or SNF - collectively referred to as providers - that does not meet the reporting requirements for their respective program may be subject to a payment reduction in its annual payment update (APU).[1]

CMS has also implemented value-based purchasing (VBP) programs to provide incentive payments to providers who deliver high quality care to patients, as measured by their performance on specific quality metrics. Currently, this package reflects burden associated with the SNF VBP program.

These QRPs and SNF VBP Program include quality measures calculated using data collected through claims, staffing data, standardized assessment tools, patient surveys, and the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). SNFs participating in the SNF QRP and VBP Program are also required to participate in a MDS data validation process.

Quality measures calculated using data collected through claims are referred to as claims-based measures. Claims data are reported to Medicare for payment purposes, and there is no additional burden required from providers. Quality measures calculated from staffing data use the data submitted by SNFs to the Payroll-based Journal as required by Section 6106 of the Affordable Care Act (ACA), and there is no additional burden required from providers.

The remaining data submission requirements are currently approved under separate OMB control numbers as defined in Table 1 below.

Table 1. OMB Control Numbers for Chronic and Post-Acute Quality Programs

Program	Requirement	OMB Control Number
Hospice QRP	Standardized patient-level data	0938-1153

[1] For the IRF Prospective Payment System, the annual update to IRF payments is called the Annual Impact Factor (AIF).

Program	Requirement	OMB Control Number
Hospice QRP	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey data	0938-1257
HH QRP	Standardized patient assessment data required under section 1899B(b)(1) of the Act	0938-1279
HH QRP	HH CAHPS® survey data	0938-1066
IRF QRP	Standardized patient assessment data required under section 1899B(b)(1) of the Act	0938-0842
IRF QRP	Measure data submitted through the CDC's NHSN	0920-0666
LTCH QRP	Standardized patient assessment data required under section 1899B(b)(1) of the Act	0938-1163
LTCH QRP	Measure data submitted through the CDC's NHSN	0920-1317 0920-0666
SNF QRP	Standardized patient assessment data required under section 1899B(b)(1) of the Act	0938-1140
SNF QRP	Measure data submitted through the CDC's NHSN	0920-1317
SNF VBP Program and SNF QRP	Data Validation process	0938-1472

B. Justification

This request for a new information collection includes burden for certain procedural requirements associated with the HH QRP, Hospice QRP (HQRP), IRF QRP, LTCH QRP, SNF QRP and the SNF VBP Program.

1. Need and Legal Basis

(a) Home Health Quality Reporting Program

The reporting of quality data by HHAs is mandated by Section 1895(b)(3)(B)(v)(II) of the Social Security Act ("the Act"). This statute requires that "each home health agency shall submit to the Secretary of Health and Human Services (Secretary) such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause." On January 25, 1999, CMS published an interim final rule with comment period (64 FR 3748) requiring electronic reporting of data from the Outcome and Assessment Information Set (OASIS) as a Condition of Participation for home health agencies beginning July 19, 1999.

Section 1895(b)(3)(B)(v)(I) of the Act states that "for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points." HHAs are required to

submit OASIS assessments and HH CAHPS data to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act.

Section 2(a) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014[2] (IMPACT Act of 2014) (Pub. L. 113-185, enacted on Oct. 6, 2014), required that the Secretary specify not later than the applicable specified application date, as defined in section 1899B(a)(2)(E), quality measures on which HHAs are required to submit standardized patient assessment data described in section 1899B(b)(1) and other necessary data specified by the Secretary. Section 1899B(c)(2)(A) requires, to the extent possible, the submission of such quality measure data through the use of a post-acute care (PAC) assessment instrument and the modification of such instrument as necessary to enable such use; for HHAs, this requirement refers to the OASIS.

(b) Hospice Quality Reporting Program

Section 1861(u) of the Act established hospices as a provider of services. Section 1861(dd) of the Act defines hospice care and the hospice program, and section 1861(dd)(2)(G) of the Act permits the Secretary to impose "such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services."

Section 3004(c) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act [ACA]), which added section 1814(i)(5)(A)(i) to the Act (The Act), authorized the establishment of a new QRP for hospices. Section 1814(i)(5)(A)(i) of the Act requires that hospices must submit quality data in a form, manner, and time specified by the Secretary. CMS established the HQRP in the FY 2012 Hospice Wage Index Final Rule (76 FR 47318 through 47324, and 47325 through 47326).[3] Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA 2021 (Pub. L. 116-260) to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points

In the FY 2025 Hospice Wage Index and Payment Rate Update final rule (89 FR 64202), CMS finalized the implementation of a hospice patient-level item set to be used by all hospices to collect and submit standardized data on each patient admitted to hospice. Beginning October 1, 2025, the Hospice Outcomes and Patient Evaluation (HOPE) is used to support the standardized collection of the requisite data elements to calculate quality measures. Hospices are required to complete and submit HOPE admission and HOPE discharge for each patient, as well as a HOPE Update Visit (HUV) assessment, when applicable, for FY 2027 APU determination.

(c) IRF Quality Reporting Program

Section 3004(b) of the ACA, which added section 1886(j)(7) to the Act, authorized the establishment of a new QRP for IRFs. Section 1886(j)(7) of the Act requires that IRFs submit quality data in a form, manner, and time specified by the Secretary. Further, section

[2] 113th Congress of the U.S.A. (2014, October 6). Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, Public Law 113-185, H.R. 4994. https://www.govinfo.gov/content/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf

[3] Medicare Program; Hospice Wage Index for Fiscal Year 2012; Final Rule, Federal Register/Vol. 76, No. 150 August 4, 2011. Government Publishing Office

1886(j)(7)(A)(i) of the Act requires the Secretary to reduce the annual payment update (i.e., the AIF for IRFs) with respect to a fiscal year by 2 percentage points for any IRFs that do not submit data to the Secretary in accordance with requirements established by the Secretary for that fiscal year, beginning in fiscal year 2014. CMS established the IRF QRP in the FY 2012 IRF Prospective Payment System (PPS) final rule (76 FR 47873 through 47883). Since October 1, 2012, the IRF-Patient Assessment Instrument (PAI) has been used to collect quality measure data, using data items in the Quality Indicator section.

Section 2(a) of the IMPACT Act requires that the Secretary specify not later than the applicable specified application date, as defined in section 1899B(a)(2)(E), quality measures on which IRF providers are required to submit standardized patient assessment data described in section 1899B(b)(1) and other necessary data specified by the Secretary. Section 1899B(c)(2)(A) requires, to the extent possible, the submission of the such quality measure data through the use of a post-acute care (PAC) assessment instrument and the modification of such instrument as necessary to enable such use; for IRFs, this requirement refers to the IRF-PAI.

(d) LTCH Quality Reporting Program

Section 3004(a) of the ACA which added section 1886(m)(5) to the Act, authorized the establishment of a new QRP for LTCHs and requires that LTCHs submit quality data in a form, manner, and time specified by the Secretary. The LTCH QRP was established in the fiscal year (FY) 2012 IPPS/LTCH PPS final rule (76 FR 51743 through 51756) pursuant to Section 3004 of the Affordable Care Act.

Since October 1, 2012, the LTCH Continuity and Assessment Record (CARE) Data Set (LCDS) has been used to collect quality measure data. Beginning in FY 2014, LTCHs that fail to submit quality data to CMS are subject to a 2-percentage point reduction in their annual payment update.

Section 2(a) of the IMPACT Act requires that the Secretary specify not later than the applicable specified application date, as defined in section 1899B(a)(2)(E), quality measures on which LTCH providers are required to submit standardized patient assessment data described in section 1899B(b)(1) and other necessary data specified by the Secretary. Section 1899B(c)(2)(A) requires, to the extent possible, the submission of such quality measure data through the use of a PAC assessment instrument and the modification of such instrument as necessary to enable such use; for LTCHs, this requirement refers to the LCDS.

(e) SNF Quality Reporting Program

Section 2(c)(4) of the IMPACT Act added section 1888(e)(6)(A)(i) requires that SNFs submit data as applicable in accordance with sections 1888(e)(6)(B)(i)(II)-(III) beginning with FY 2018.

Section 2(a) of the IMPACT Act amended the Act by adding section 1899B, which requires, among other things, SNFs to report standardized patient assessment data through the use of a PAC assessment instrument and the modification of such instrument as necessary to enable such use; for SNFs, this requirement refers to the Minimum Data Set (MDS).

Section 1888(e)(6)(B)(i)(II) of the Act requires that each SNF submit data on quality measures specified under section 1899B(c)(1) of the Act and data on resource use and other measures specified under section 1899B(d)(1) of the Act in a manner and within the timeframes specified by the Secretary. In addition, section 1888(e)(6)(B)(i)(III) of the Act requires, for FYs beginning on or after October 1, 2018, that each SNF submit standardized patient assessment data required under section 1899B(b)(1) of the Act in a manner and within the timeframes specified by the Secretary. Section 1888(e)(6)(A)(i) of the Act requires that, for FYs beginning with FY 2018, if a SNF does not submit data, as applicable, on quality and resource use and other measures in accordance with section 1888(e)(6)(B)(i)(II) of the Act and standardized patient assessment in accordance with section 1888(e)(6)(B)(i)(III) of the Act for such FY, the Secretary reduce the market basket percentage described in section 1888(e)(5)(B)(ii) of the Act by 2 percentage points.

Section 1888(h)(12)(A) of the Act (as added by section 111(a)(4) of Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260)), requires the Secretary to apply a process to validate data submitted under the SNF QRP and the SNF VBP Program. To comply with section 1888(h)(12)(A) of the Act, CMS finalized in the FY 2025 SNF PPS final rule (89 FR 64118 through 64122) that SNFs participating in the SNF QRP will be required to participate in the SNF MDS validation process beginning with the FY 2027 SNF QRP. In addition, CMS finalized a policy to reduce a SNF's otherwise applicable annual market basket percentage update by 2 percentage points if the SNF fails to submit the required medical records.

(f) SNF Value-Based Purchasing (VBP) Program

In Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA), Congress added Sections 1888(g) and (h) to the Act, which required the Secretary of the Department of Health and Human Services (HHS) to establish a SNF VBP Program. In Section 111 of the Consolidated Appropriations Act, 2021 (CAA), Congress amended Section 1888(h) of the Act to allow the Secretary to apply up to nine additional measures to the SNF VBP Program.

Collectively, PAMA and the CAA specify that under the SNF VBP Program, SNFs are evaluated by their performance on a hospital readmission measure and no more than nine additional measures determined appropriate by the Secretary; are assessed on both improvement and achievement for each measure, and scored on the higher of the two; receive quarterly confidential feedback reports containing information about their performance; and earn incentive payments based on their performance.

CMS began applying incentive payments for SNFs on October 1, 2018. All SNFs paid under Medicare's SNF PPS are subject to the SNF VBP Program. Inclusion in the SNF VBP Program does not require any action on the part of SNFs.

For the SNF VBP Program, the FY 2027 program year will be the first year to account for MDS-based measures based on data from the FY 2025 performance period. To comply with section 1888(h)(12)(A) of the Act, in the FY 2024 SNF PPS final rule (88 FR 53325), CMS finalized for the SNF VBP Program the initial components of a validation process for MDS-based measures to start beginning with the FY 2027 program year.

(g) Administrative Procedures for the Chronic and Post-Acute Care Quality Programs

CMS has implemented procedural requirements that align the current QRPs, including the HH QRP, HQRP, IRF QRP, LTCH QRP, SNF QRP and SNF VBP Program. These procedural requirements involve submission of forms to comply with quality and VBP Program requirements. While the forms are used for multiple programs, they are included under OMB control number 0938-NEW to reduce administrative burden and the potential for errors when updates are necessary.

The QRPs use three administrative procedures: (1) Reconsideration Request; (2) Request for an Extension for a Reconsideration; and (3) Request for an Extraordinary Circumstances Exception/Extension (ECE). These procedures are used across five QRPs (HH QRP, HQRP, IRF QRP, LTCH QRP, and SNF QRP), In addition, the SNF VBP Program uses three administrative procedures: (1) Request for Review and Corrections to Measure Calculations; (2) Request for Reconsideration of a Review and Correction Decision; and (3) Request for an ECE. These procedures are listed in Table 2. DCPAC has associated forms which providers complete to initiate their request(s). However, these request forms are not required, and most providers will not need to complete the request form in any given year. The burden, if applicable, for providers associated with the administrative procedures is discussed in section B.12.

Table 2. Administrative Procedures for Chronic and Post-Acute Care Quality Programs

Procedure Name	HH	Hospice	IRF	LTCH	SNF
Reconsideration Request	QRP	QRP	QRP	QRP	QRP
Request for an Extension for a Reconsideration	QRP	QRP	QRP	QRP	QRP
Request for an Extraordinary Circumstances Exception/Extension	QRP	QRP	QRP	QRP	QRP
Request for an Extraordinary Circumstances Exception/Extension					VBP
Request for a Review and Corrections to Measure Calculations					VBP
Request for Reconsideration of a Review and Correction Decision					VBP

(i) Reconsideration Request

Providers determined to be non-compliant with their QRP following the final submission deadline will receive a letter of notification from CMS via the My Reports folder within the Internet Quality Improvement and Evaluation System (iQIES) and from their Medicare Administrative Contractor (MAC) via the United States Postal Service or via email. Non-Compliance letters will include instructions for requesting reconsideration of this decision. This letter also includes the reason(s) for failing APU compliance.

When CMS determines that a provider did not meet one or more of their respective QRP requirement(s), the provider may submit a request for reconsideration to CMS using the

Reconsideration Request form, by the deadline identified on the APU Notification Letter it received.

Because the reconsideration requirements are associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), they are exempt from the requirements of the PRA.

(ii) Request for an Extension for a Reconsideration

CMS may grant a request by a provider to extend the deadline to submit its reconsideration request, so long as the provider requested the extension and demonstrated that extraordinary circumstances existed that prevented the filing of a reconsideration request by the 30-day deadline.

Specifically, a provider may request an extension to file a request for reconsideration of a noncompliance determination if, during the period to request a reconsideration, the provider was affected by an extraordinary circumstance beyond their control (for example, a natural or man-made disaster). The provider must submit a request for an extension to file a reconsideration request to CMS no later than 30 calendar days from the date of the written notification of noncompliance. A provider may use the Reconsideration Request Form provided on the Program's QRP Reconsideration and Exception and Extension webpage and indicate the Request Type is a Request for an Extension for a Reconsideration.

Because the reconsideration requirements are associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), they are exempt from the requirements of the PRA.

(iii) Request for an Extraordinary Circumstance Exception/Extension (ECE)

CMS offers a process for providers to request exceptions to the reporting of required quality data for one or more quarters when they experience an extraordinary circumstance beyond the provider's control. The SNV VBP ECE policy also allows SNFs to request an exception or extension if a SNF can demonstrate that an extraordinary circumstance affected the care that it provided to its patients and thus affected its subsequent measure performance. If granted, CMS would exclude the calendar months during which the SNF was affected by the extraordinary circumstance from measure calculations. The provider must submit its request within 90 calendar days of an extraordinary circumstance event for all programs. A provider may use the Request for an Extraordinary Circumstances Extension/Exception (ECE) provided on the Program's QRP Reconsideration and Exception and Extension to submit their request with supporting documentation. CMS may grant the exception or extension for one or more quarters.

(iv) Review and Corrections to Measure Calculations Request

Before any data in the quarterly confidential feedback reports are publicly reported, SNFs have an opportunity to review their results and request corrections; this is known as the SNF VBP Program Review and Correction (R&C) policy. The SNF VBP Program R&C process has two phases:

- Phase 1: Review and submit corrections to the calculation of the measure results for the baseline and performance periods (applies to Full-Year Workbooks only).
- Phase 2: Review and submit corrections to performance scores and ranking (applies to Performance Score Reports only).

SNFs may review and request corrections after dissemination of the applicable report. SNFs must submit correction requests to the SNF VBP Program Help Desk at SNFVBPquestions@cms.hhs.gov within 30 calendar days after dissemination of the applicable report. CMS will review all requests and notify the requesting SNF of the final decision. CMS will implement any approved corrections before any affected data become publicly available.

Because the reconsideration requirements are associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), they are exempt from the requirements of the PRA.

(v) Request for Reconsideration of a Review and Correction Decision

CMS has implemented an additional appeal process available to eligible SNFs participating in the SNF VBP Program, beyond the existing Review and Corrections process. SNFs may request this additional reconsideration only if they first submit a valid review and correction request (specified above) and are dissatisfied with CMS's decision. SNFs must submit reconsideration requests to the SNF VBP Program Reconsideration Contractor at SNFVBPReconsiderations@EconometricaInc.com within 15 calendar days of receiving CMS's decision on the valid review and correction request submitted under section §§ 413.338(f)(2) or (3).

Because the reconsideration requirements are associated with an administrative action (5 CFR 1320.4(a)(2) and (c)), they are exempt from the requirements of the PRA.

2. Information Users

These QRPs, as pay-for-reporting programs, strive to have a streamlined measure set that provides meaningful measurement and differentiates providers by quality of care while limiting burden to the fullest extent possible. CMS provides confidential feedback reports that providers may use to assess their performance and operationalize quality improvement activities throughout the quality reporting period. These reports include the data that CMS has collected from the provider and the provider's claims, and some also include information about how the provider's data compares relative to the performance of other providers.

CMS also uses SNF quality reporting information to set payment adjustments for the SNF VBP program. For example, the SNF VBP Interim (Partial-Year) Workbook and Full-Year Workbooks allow SNFs to assess their current performance in each measure. The SNF VBP Performance Score Report allows SNFs to assess how the SNF VBP Program scored their

current measure performance and determine the SNF VBP Program's incentive payment adjustments for the coming fiscal year.

The measure information is also used by CMS to direct its contractors to focus on particular areas of improvement and to develop quality improvement initiatives. This information is also available to Medicare beneficiaries, as well as to the general public, by providing QRP and VBP information on the Compare tool and in the Provider Data Catalog (PDC) available at data.cms.gov to assist them in making decisions about their healthcare. CMS sometimes conducts focus groups or market testing prior to publicly reporting quality data on the Compare tool hosted by HHS or its successor website(s) to get feedback on ways to make the website more user-friendly. Feedback from these focus groups has helped CMS understand how beneficiaries and consumers use the Compare tool hosted by HHS or its successor website(s). Under emergency circumstances, consumers choose PAC and Hospice providers based on proximity, reputation, prior experience, or their doctor's recommendation. When patients and their family members may have the time and motivation to consider options and engage in informed decision making, they have expressed interest in information such as the provider's track record in treating their condition, safety and infection rates, and a PAC provider's recognized areas of expertise, as well as to take into consideration their doctor's recommendation. The public display of quality measure data by CMS imposes no additional burden on PAC providers.

Under section 1890A(a)(6) of the Act, CMS is required to evaluate the impact and efficiency of CMS measures in the QRPs and VBP and to post the report every three years. Following the compilation of data from the HH QRP, HQRP, IRF QRP, LTCH QRP, SNF QRP and VBP Program, and other CMS programs, CMS' findings were formally written into the latest triennial National Impact Assessment Report, which was released in CY 2024.[4]

3. Use of Information Technology

CMS uses information technology to decrease the burden associated with the administrative procedures relevant to the HH QRP, HQRP, IRF QRP, LTCH QRP, SNF QRP and the SNF VBP Program. This is accomplished through strategies that (1) streamline information and submission processes, (2) minimize costly documentation requirements, and (3) utilize information technology for improving communication.

First, CMS created one request form for providers to submit to request an extraordinary circumstance exception/extension related to their program requirements. The form ensures the information requested is limited to the minimum data required for CMS to make decisions about exception and/or extension requests for the Hospice, HH, IRF, LTCH and SNF QRPs and the SNF VBP Program requirements. When utilized, this request form ensures providers are sending complete data. The form is available free of charge and is standardized for all users across all Chronic and PAC quality programs.

[4] 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.

Second, CMS provides customer support for questions or problems encountered by the providers. For example, we have dedicated help desks to respond to questions providers may have about submitting their request(s). CMS also provides an email acknowledgment within five (5) business days upon receipt of the reconsideration or exception/extension request.

Third, CMS offers providers the ability to sign up for listservs that send out timely and important new information, reminders, and alerts via electronic mail related to the administrative procedures relevant to the QRPs and SNF VBP Program.

Fourth, CMS has developed program specific trainings on understanding the requirements of the QRPs, including how providers can achieve a full annual payment update, and the SNF VBP performance calculations. These trainings will give providers the information they need to request a reconsideration, request a reconsideration of a review and correct decision, and how to request an exception or extension related to their program requirements. These trainings can be found on program specific web pages (found in Table 3) and are free and available at all times to providers.

Table 3. Program-Specific Training Web Pages

Program	Location of Resources
Home Health QRP	https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-training
Hospice QRP	https://www.cms.gov/medicare/quality/hospice/hqrp-training-and-education-library
IRF QRP	https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-training
LTCH QRP	https://www.cms.gov/medicare/quality/long-term-care-hospital/ltch-quality-reporting-training
SNF QRP	https://www.cms.gov/medicare/quality/snf-quality-reporting-program/training
SNF VBP Program	https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing

Fifth, CMS established program-specific web pages where they communicate exceptions or extensions to providers without their request if CMS determines that an extraordinary circumstance affects an entire region or locale or one of CMS's data collection systems experiences a systemic problem directly affecting the ability of providers to submit data. Providers can also download the request forms discussed in B.1.(g). These web pages (found in Table 4) publish new information related to the administrative procedures and are always available to providers.

Table 4. Program-Specific Reconsideration and Exception and Extension Web Pages

Program	Location of Resources
HH QRP	https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-reconsideration-and-exception-extension

Program	Location of Resources
Hospice QRP	https://www.cms.gov/medicare/quality/hospice/hqrp-reconsideration-requests and https://www.cms.gov/medicare/quality/hospice/hqrp-extensions-and-exemption-requests
IRF QRP	https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-reconsideration-and-exception-extension
LTCH QRP	https://www.cms.gov/medicare/quality/long-term-care-hospital/ltch-quality-reporting-reconsideration-and-exception-extension
SNF QRP	https://www.cms.gov/medicare/quality/snf-quality-reporting-program/reconsideration-and-exception-extension
SNF VBP Program	https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/confidential-feedback-reporting-review-and-corrections and https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing/extraordinary-circumstance-exception

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS. We prioritize efforts to reduce burden for the administrative procedures related to the HH, Hospice, IRF, LTCH and SNF QRPs and the SNF VBP Program.

5. Small Business

CMS acknowledges that some small providers may experience difficulties complying with request for reconsideration or exception/extension requirements and having CMS forms to collect this information may reduce the stress and anxiety providers may experience.

Specifically, a small entity can be defined as a small organization and may include small businesses, non-profit organizations, and small governmental jurisdictions and is not dominant in its field. The number of small providers using 2024 data is estimated to be: 13.8% (or 1,362) HHAs; 12.6% (or 849) Hospice agencies; 12% (or 145) of IRFs; 5.2% (or 17) of LTCHs; and 27.5% (or 4,209) of SNFs

Provider participation in the submission of quality data for the Chronic and PAC's QRPs and SNF VBP Program is mandated by provisions the Act. Specifically, 1895(b)(3)(B)(v) for HHAs; Section 1814(i)(5) for Hospice agencies; Section 1886(j)(7) for IRF; Section 1886(m)(5) for LTCH; and Section 1888(e)(6) for SNF.

Small business providers viewing the data collection and submission requirements for the

voluntary processes described in this package as a burden can elect not to participate. However,

if a provider does not submit the required quality data, this provider may be subject to a reduction in their payment update during that rate year.

6. Less Frequent Collection

CMS has designed administrative procedures and associated forms to be the minimum necessary to make a definitive decision (approval, denial, or partial approval) and communicate the decision effectively in writing back to the provider.

These procedures are used across five quality programs (HH QRP, HQRP, IRF QRP, LTCH QRP, SNF QRP) and one VBP program (SNF VBP Program). These administrative procedures are available on a need-to-use, exception basis, and most providers will not need to complete any of these procedures in any given year. The burden for providers associated with procedures is discussed in section B.12.

7. Special Circumstances

There are no special circumstances.

8. *Federal Register* Notice/Outside Consultation

The 60-day *Federal Register* notice published on February 13, 2026 (91 FR 3506). CMS received numerous comments however they were out of the scope of the collection. Please see the Response to Comments document.

The 30-day Federal Register notice published on April 27, 2026 (91 FR 22536).

9. Payment/Gift to Respondent

There will be no payments and no gifts to respondents for the use of these procedures.

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 (PII) contained in the data submitted. Each of the administrative procedures included in this PRA package include clear instructions warning providers not to include patient health information (PHI) and/or PII in the documentation they submit to CMS for review. CMS also clearly communicates on these forms that they will not review requests containing sensitive information or any documentation that violates the Health Insurance Portability and Accountability Act (HIPAA) laws.

To address concerns about confidentiality of patient/resident data, we also provide that a facility and a State may not release patient/resident-identifiable information to the public and may not release the information to an agent or contractor without certain safeguards (42 CFR 483.20(f)(5) and 483.315(j)). Data will be kept private to the extent allowed by law.

11. Sensitive Questions

There are no questions of a sensitive nature associated with these procedures.

12. Burden Estimate (Total Hours & Wages)

(a) Background

As noted in section B.1(g)(i), (ii), (iv), and (v), information collection requirements imposed subsequent to an administrative action are not subject to the PRA under 5 CFR 1320.4(a)(2). Therefore, the estimates provided in this section only include the burden associated with Requests for an Extraordinary Circumstance Exception/Extension.

(b) Wage Estimates

For the purposes of burden estimation, we assume all activities associated with the administrative procedures described in section B.1.(g)(iii) for these five provider types will be completed by Medical Records Specialists. These staff are qualified to complete the tasks associated with the completion of these applicable procedures.

For the purposes of calculating the costs associated with the collection of information requirements, we obtained median hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2024 National Occupational Employment and Wage Estimates.[5] To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 5.

Table 5. U.S. Bureau of Labor and Statistics' May 2024 National Occupational Employment and Wage Estimates.

Occupation title	Occupation code	Median Hourly Wage ($/hr)	Overhead and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Medical Records Specialist	29-2072	$24.16	$24.16	$48.32

(c) Assumptions

According to the On-Line Survey and Certification System (OSCAR), there were approximately 9,821 HHAs, 6,735 Hospice agencies, 1,169 IRFs, 327 LTCHs, and 15,288 SNFs in 2024, for a total of 33,340 providers.

Using information from CY 2024, we estimate that there would be approximately 3 Requests for an ECE from HHAs, 13 Requests for an ECE from Hospices, 25 Requests for an ECE from IRFs, 3 Requests for an ECE from LTCHs, and 28 Requests for an ECE from SNFs annually.

(d) Burden Associated with Completion of Procedures for the FY/CY 2029 Payment Determination

[5] https://www.bls.gov/oes/current/oes_nat.htm.

As previously stated, our burden estimates exclude burden associated with these programs' other reporting requirements that are associated with the OMB control numbers found in Table 1 in Section A of this package.

The form listed in section B.1.g.(iii) is not completed by PAC providers on a regular basis. Because the Request for an ECE Form is used across six quality programs (HH QRP, HQRP, IRF QRP, LTCH QRP, SNF QRP and SNF VBP Program), we have included a burden calculation using this form as an example of "all other forms" within this PRA package. This form is intended to be submitted by participants only if they seek an extension or exception from data reporting requirements due to such extraordinary circumstances. For example, in CY 2024, 28 ECE requests were submitted by SNFs for an extension or exception from reporting requirements for the SNF QRP.

Consistent with estimates in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49762), we estimate a burden of 15 minutes (0.25 hours) per provider to complete the applicable form. Therefore, we estimate the information collection burden per provider associated with completing this form to be $12.08 (0.25 hours x $48.32/hour).

Based on the information from CY 2024, there were approximately 3 Requests for an ECE from HHAs, 13 Requests for an ECE from Hospices, 25 Requests for an ECE from IRFs, 3 Requests for an ECE from LTCHs, and 28 Requests for an ECE from SNFs. As a result, we estimate the total burden calculation for the submission of 72 Requests for an ECE Forms to be 1,080 minutes (15 minutes x 72 requests) or 18.0 hours (1,080 minutes / 60 minutes) across 33,340 providers.

As shown in Table 6, across 33,340 providers, we estimate a total annual cost of $869.76 (18.0 hours x $48.32) for completion of the administrative form to request an exception or extension from the respective program's QRP requirements in FY/CY 2029.

Table 6. Burden Estimates for Completion of Forms for the FY/CY 2029 Payment Determination

Program and Activity	***Estimated time per record (minutes)***	***Estimated Number of requests per respondent per year***	***Estimated Number of respondents per year***	***Total Burden Hours for FY 2029 payment determination***
Home Health Agencies (9,768)				
Request for an Extraordinary Circumstance Exception/Extension	15	1	3	0.75
Subtotal HHA activities				**0.75**
Hospice Agencies (6,735)				
Request for an Extraordinary Circumstance Exception/Extension	15	1	13	3.25
Subtotal Hospice activities				**3.25**
Inpatient Rehabilitation Facilities (1,169)				
Request for an Extraordinary Circumstance Exception/Extension	15	1	25	6.25
Subtotal Inpatient Rehabilitation Facilities activities				**6.25**

Program and Activity	*Estimated time per record (minutes)*	*Estimated Number of requests per respondent per year*	*Estimated Number of respondents per year*	*Total Burden Hours for FY 2029 payment determination*
Long-Term Care Hospitals (327)				
Request for an Extraordinary Circumstance Exception/Extension	15	1	3	0.75
Subtotal Long-Term Care Hospital activities				**0.75**
Skilled Nursing Facilities (15,288)				
Request for an Extraordinary Circumstance Exception/Extension	15	1	28	7.0
Subtotal SNF activities				**7.0**
Total Annual Burden for Chronic and PAC's QRPs and the SNF VBP			72	**18.0**
Medical Records Specialist hourly labor rate				**$ 48.32**
Total Annual Cost for Requesting an Extraordinary Circumstances Extension/Exception				**$ 869.76**

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs.

14. Cost to Federal Government

The cost to the Federal Government for maintaining program activities is for managing requests, reviewing requests for completeness, notifying providers of decisions, and providing ongoing technical assistance to providers. These costs are estimated at $15,000 annually for the program management contract. Additionally, this program requires one CMS staff at a GS-13 Step 5 level for approximately 80 hours annually. With approximate annual salaries of $133,692[6], annual CMS staff costs are estimated to be $5,142.40 [($133,692/2,080 hours = $64.28/hour); $64.28/hour x 80 hours = $5,142.40]. The total annual cost to the Federal Government is $20,142.

15. Program or Burden Changes

This is a new information collection.

16. Publication/Tabulation Dates

There are no publication dates.

[6] Salary Table 2024-DCB, Effective January 2024 for Locality Pay Area of Washington-Baltimore-Arlington, DC-MD-VA-WV-PA.

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 respective program's websites listed in Table 3.

18. Certification Statement

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

C. Appendices:

Appendix A

Request for an Extraordinary Circumstance Exception/Extension (ECE) Form

Reconsideration Request Form