Supporting Statement – Part A

Submission of Information for the PPS-Exempt Cancer Hospital Quality Reporting Program: FY 2027 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) PPS Final Rule
(OMB# 0938-1175; CMS-10431)

A. Background

This is a revision of the currently approved information collection request. The Centers for Medicare & Medicaid Services' (CMS's) quality reporting programs promote higher quality, more efficient healthcare for consumers, including Medicare beneficiaries by collecting and reporting quality-of-care metrics. This information informs consumer decision-making and incentivizes healthcare facilities to make continued improvements.

Specifically, CMS has implemented quality measure reporting programs for multiple settings, including for the PPS-exempt cancer hospital (PCH) setting, to achieve its overarching priorities and initiatives, including the Meaningful Measures 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 2028 program year are currently approved under OMB control number 0938-1175 (expiration date January 31, 2029). This request covers data collection requirements for the FY 2029 program year and subsequent years. This revised information collection request includes changes in burden associated with the adoption of the Advance Care Planning and Malnutrition Care Score electronic clinical quality measures (eCQMs), as well as updated wage rates.

B. Justification

1. Need and Legal Basis

Pursuant to section 1866(k)(1) of the Social Security Act, starting in FY 2014 and for subsequent fiscal years, PCHs, as described in section 1886(d)(1)(B)(v) of the Social Security Act, shall submit selected quality measures to the CMS. Such data shall be submitted in a form and manner and at a time specified by the Secretary.

We continue to require PCHs to meet the procedures previously set forth for making public the measure information submitted under the PCH Quality Reporting Program. However, PCHs that fail to meet PCH Quality Reporting requirements do not receive any payment penalties.

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

a. PCH Quality Reporting Program Quality Measures

The PCH Quality Reporting Program collects and publicly reports data on quality-of-care metrics for the PCH setting. Measure data are currently submitted via one of several modes: (1) digital, (2) claims-based, (3) survey-based; and (4) web-based, as seen in Table 1.

Digital measures include eCQMs and web-based measures. For eCQMs, information is electronically extracted from electronic health records and/or health information technology systems. Web-based measure data are submitted to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) under OMB control number 0920-0666 (expiration date March 31, 2029).

For survey-based measures, PCHs are required to submit data for the Documentation of Goals of Care Discussions Among Cancer Patients via CMS's Hospital Quality Reporting (HQR) system, and for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, PCHs are required to administer the survey and submit the survey data to CMS via an approved vendor. HCAHPS survey administration burdens are captured under OMB control number 0938-0981 (expiration date November 30, 2027).

Claims-based measures use information derived through Medicare Fee-for-Service (FFS) claims and beneficiary enrollment data. Because these data are already submitted by PCHs to CMS for payment purposes, claims-based measures do not require additional reporting burden from PCHs.

Table 1. Currently Approved PCH Quality Reporting Program Measures for the FY 2028 Program Year and Subsequent Years

Measure Type and Name
Safety and Healthcare-Associated Infection Measures (Web-based Measures)
Central Line-Associated Bloodstream Infection Outcome Measure (CLABSI)*
Catheter-Associated Urinary Tract Infection Outcome Measure (CAUTI)*
Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (currently includes SSIs following Colon Surgery and Abdominal Hysterectomy Surgery)*
Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure*
Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure*
Influenza Vaccination Coverage Among Healthcare Personnel (HCP)*
COVID-19 Healthcare Personnel Vaccination Coverage Among Healthcare Personnel**
Patient Safety Structural Measure*
End-of-Life Measures (Claims-based Measures)
Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo)
Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice)
Proportion of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in

the Last 30 Days of Life (EOL-ICU)
Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH)
Claims-Based Outcome Measures
Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
30-Day Unplanned Readmissions for Cancer Patients
Surgical Treatment Complications for Localized Prostate Cancer
Patient Engagement/Experience of Care Measures (Survey-based Measures)
Documentation of Goals of Care Discussions Among Cancer Patients
HCAHPS Survey***
eCQMs (Digital)
Advance Care Planning****
Malnutrition Care Score****

*Burden for these measures are accounted for under OMB control number 0920-0666.
**Burden for this measure is accounted for under OMB control number 0920-1317. This measure has been finalized for removal in the FY 2027 IPPS/LTCH final rule.
***Burden for this measure is accounted for under OMB control number 0938-0981.
****These measures were adopted in the FY 2027 IPPS/LTCH PPS final rule.

In the FY 2027 IPPS/LTCH PPS final rule, we adopted two measures with voluntary reporting for the CY 2028 reporting period/FY 2030 program year followed by mandatory reporting beginning with the CY 2029 reporting period/FY 2031 program year: (1) the Advance Care Planning eCQM; and (2) the Malnutrition Care Score eCQM.

We also removed the COVID–19 Vaccination Coverage among HCP measure beginning with the CY 2026 reporting period/FY 2028 program year; however, the related burden reduction for this change is associated with OMB control number 0920-1317.

b. PCH Quality Reporting Program Administrative Forms

CMS has implemented procedural requirements for the PCH Quality Reporting Program in alignment with other quality reporting programs. These procedural requirements involve submission of forms to comply with the PCH Quality Reporting Program requirements.

The PCH Quality Reporting Program uses four administrative forms: (1) Notice of Participation Form; (2) Data Accuracy and Completeness Acknowledgement (DACA) Form; (3) Measures Exception Form; and (4) Extraordinary Circumstances Exception (ECE) Form. These forms are used across ten quality programs (Hospital Inpatient Quality Reporting Program, Hospital Outpatient Quality Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, PCH Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Hospital Value-Based Purchasing Program, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, End Stage Renal Disease Quality Incentive Program, and Rural Emergency Hospital Quality Reporting Program); therefore, we have included the burden associated with these forms under OMB control number 0938-1022 (Hospital Inpatient Quality Reporting Program). Most of these forms are not completed on an annual basis, but on a need-to-use, exception basis, and most PCHs will not need to complete any of these forms in any

given year (except for the DACA Form). Thus, the burden for providers associated with forms utilized in the PCH Quality Reporting Program is nominal, if any.

a. Notice of Participation Form

To begin participation in the PCH Quality Reporting Program, PCHs must complete a Notice of Participation. The Notice of Participation explains the participation and reporting requirements for the program. PCHs that previously indicated their intent to participate will be considered active PCH Quality Reporting Program participants until they submit a withdrawal to CMS.

b. DACA Form

Annually, PCHs participating in 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.

c. Measures Exception Form

PCHs that performed a combined total of 9 or fewer colon surgeries and abdominal hysterectomies in the calendar year prior to the reporting year are eligible to submit the Measure Exception Form to reduce the burden of reporting the SSI measure.

d. ECE Request Form

CMS offers a process for PCHs to request exceptions or extensions to the reporting of required quality data when a PCH experiences an extraordinary circumstance not within the control of the PCH, such as a cyberattack or natural disaster. The CMS Quality Program ECE Request Form indicates that for non-eCQM circumstances, the request must be submitted within 60 calendar days of an extraordinary circumstance event for all programs, and that for eCQMs it must be submitted by a specific deadline.

2. Information Users

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

The availability of peer performance enables state agencies and CMS to identify opportunities for improvement in a PCH, and to evaluate more effectively the PCH's own quality assessment and performance improvement program.

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

PCH quality measure data will be publicly reported as early as late FY 2027 on the Compare tool hosted by HHS, currently available at: https://www.medicare.gov/care-compare, or its successor website(s), and are currently reported on the Provider Data Catalog (PDC) which can be accessed at https://data.cms.gov/provider-data/. These sites provide information for consumers and their families about the quality of care provided by an individual hospital, allowing them to see how well patients of one facility fare compared to those in other facilities and to state and national averages. Modeled after the Hospital Inpatient Quality Reporting Program, the PCH Quality Reporting Program uses quality measures to help the public make informed decisions when choosing a PCH; to monitor the care the PCH is providing; and to stimulate the PCH to further improve quality and identify optimal practice.

3. Use of Information Technology

To assist PCHs in participating in standardized data collection initiatives across the industry, CMS continues to improve data collection tools with the dual goals of making data submission easier (including the automated collection of electronic patient data in electronic health records for eCQMs) and to increase the utility of the data provided by the PCHs.

As reflected by the collection and reporting of claims-based quality measures, efforts are made to reduce burden by limiting the adoption of measures requiring the submission of patient-level information that must be acquired through chart-abstraction and to employ existing data and data collection systems. The complete list of measures and data collection forms are organized by type of data collected and data collection mechanism in Table 1.

For claims-based measures, this section is not applicable, because claims-based measures use information derived through Medicare FFS claims and beneficiary enrollment data. Because these data are already submitted by PCHs to CMS for payment purposes, claims-based measures do not require additional burden from PCHs.

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect quality of care data for PCH care. Where possible, we have selected measures that are currently reported through a common mechanism for all PCHs to conduct uniform measure reporting across settings. For example, we leverage data reported to the CDC through the NHSN so as not to require duplicate reporting.

5. Small Business

Information collection requirements were designed to allow maximum flexibility specifically for small PCH providers participating in the PCH Quality Reporting Program. This effort assists small PCH providers in gathering information for their own quality improvement efforts. We define a "small hospital" as one with 1-99 inpatient beds; 4 of the 11 PCHs that report data for the PCH Quality Reporting Program meet this definition. We provide a help-desk hotline for troubleshooting, and free information available on CMS' QualityNet website through a Questions and Answers function. These activities assist small PCHs in gathering information for their quality improvement efforts and for meeting PCH Quality Reporting Program information collection requirements.

6. Less Frequent Collection

CMS has designed the collection of quality-of-care data to be the minimum necessary for reporting of data on measures that are meaningful indicators of cancer patient care, and for calculation of summary figures to be used as reliable estimates of PCH performance. Claims-based measures use information derived from Medicare FFS claims data; PCHs submit claims for reimbursement or payment per claims processing timeliness requirements. In addition, we leverage data reported to the CDC through the NHSN so as not to require duplicate reporting. To collect this information or measure data less frequently would compromise the timeliness of any calculated estimates.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice of the FY 2027 IPPS/LTCH PPS proposed rule (RIN 0938-AV79, CMS-1849-P) was published on April 14, 2026 (91 FR 19312). We received no comments regarding the burden estimates included in this PRA package. The FY 2027 IPPS/LTCH PPS final rule (RIN 0938-AV79, CMS-1849-F) was published on August 4, 2026 (91 FR 49570).

Measures adopted for the PCH Quality Reporting Program are required by statute to undergo a recognized consensus process. Section 1890(b) of the Social Security Act requires CMS to develop quality and efficiency measures through a "consensus-based entity." To fulfill this requirement, the Partnership for Quality Measurement (PQM) provides input on the Measures Under Consideration (MUC) list as part of the Pre-Rulemaking Measure Review (PRMR) process. We refer readers to https://p4qm.org/PRMR-MSR for more information on the PRMR process.

CMS is additionally supported in this program's efforts by the CDC, Health Resources and Services Administration, Agency for Healthcare Research and Quality, and the Office of the National Coordinator for Health IT. 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, including through the solicitation of comments.

9. Payments/Gifts to Respondent

Section 1866(k) of the Social Security Act applies to hospitals described in section 1886(d)(1)(B)(v) of the Social Security Act and requires PCHs to report data in accordance with the requirements of the PCH Quality Reporting Program for purposes of measuring and making publicly available information on the quality of care furnished by PCHs; however, there is no reduction in payment to a PCH that does not report data. No payments or gifts will be given to PCHs for participation.

10. Confidentiality

We pledge privacy to the extent provided by law. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted. All information collected under the PCH Quality Reporting 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 PCH-specific data will be made publicly available as mandated by statute.

Data related to the PCH Quality Reporting Program is housed in the HQR application group. CMS's HQR is a General Support System housing protected health information. Users who access CMS's 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 quality programs including the PCH Quality Reporting 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 the forms. Case-specific clinical data elements will be collected and are necessary to calculate statistical measures. These statistical measures are the basis of all subsequent improvement initiatives derived from this collection and cannot be calculated without case-specific data. Case-specific data will not be released to the public and are not releasable by requests under the Freedom of Information Act. Only PCH-specific data will be released to the public after PCHs have had an opportunity to review the data that are to be made public, as mandated by statute. The patient-specific data remaining in the CMS clinical data warehouse after the data are aggregated for release for public reporting will continue to be subject to the strict confidentiality regulations in 42 CFR Part 480.

12. Burden Estimate (Total Hours & Wages)

(a) Background

For the PCH Quality Reporting Program, the burden under this OMB-approved data collection is associated with meeting program requirements includes the time and effort associated with completing administrative requirements and collecting and submitting data on the required measures for the 11 PCHs participating in the PCH Quality Reporting Program, and not covered under another OMB-approved data collection.

In the FY 2027 IPPS/LTCH PPS final rule, we adopted two measures with voluntary reporting for the CY 2028 reporting period/FY 2030 program year followed by mandatory reporting beginning with the CY 2029 reporting period/FY 2031 program year: (1) the Advance Care Planning eCQM; and (2) the Malnutrition Care Score eCQM. Additionally, we removed the COVID–19 Vaccination Coverage among HCP measure beginning with the CY 2026 reporting period/FY 2028 program year.

(b) Burden for the FY 2028 Payment Determination

Our currently approved burden estimates are based on an assumption of 11 PCHs. For the purposes of burden estimation, we assume all activities associated with the PCH Quality Reporting Program will be completed by Medical Records Specialists, with the exception of survey completion which will be completed by patients. These staff are qualified to complete the tasks associated with the submission of data to clinical registries and the completion of any of the other applicable forms associated with activities related to the PCH Quality Reporting Program.

OMB has currently approved 2 hours at a cost of $111 for the FY 2028 program year under OMB control number 0938-1175, accounting for information collection burden experienced by 11 PCHs. As shown in Table 3, we estimate a baseline burden of 2 hours at a cost of $110 for the FY 2028 program year, accounting for updated wage rates.

These estimates exclude burden associated with several other OMB control numbers. NHSN measures are submitted separately under OMB control number 0920-0666, except for the burden associated with the COVID-19 HCP Vaccination Coverage among Healthcare Personnel measure under OMB control number 0920-1317. The burden associated with the HCAHPS Survey is also submitted separately under OMB control number 0938-0981. Finally, we do not include burden associated with claims-based measures as these measures are derived from claims data submitted by the PCHs as part of their reimbursement process and are calculated by CMS without additional information collection effort by the PCHs.

Table 2. Currently Approved Burden Estimates for the PCH Quality Reporting Program for the FY 2028 Program Year

Measure Set	***Estimated time per record (minutes) -***	***Number reporting quarters per year -***	***Number of respondents***	***Average number records per PCH***	***Annual burden (hours) per PCH***	***Total Burden Hours for FY 2028 Program***

	FY 2028 Program Year	***FY 2028 Program Year***		***per quarter***		***Year***
PATIENT ENGAGEMENT/EXPERIENCE OF CARE MEASURES						
Documentation of Goals of Care Measure	10	1	11	1	0.167	2
Total Burden Hours						**2**
Total Burden @ Medical Records Specialist labor rate (2 hours x $55.06)						**$110**

(c) Updated Hourly Wage Rate

Using the most recent data from the BLS for medical records specialists at the time of the proposed rule (SOC 29-2072), entitled, the May 2024 Occupational Employment and Wage Estimates, we use the median hourly wage for medical records specialists for the industry, "general medical and surgical hospitals," which is $27.53.[2] We believe the industry of "general medical and surgical hospitals" is more specific to this program compared to other industries under medical records specialists, such as "office of physicians" or "nursing care facilities". We calculated the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage. 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 ($27.53 × 2 = $55.06) to estimate total cost is a reasonably accurate estimation method. Accordingly, we calculate cost burden to PCHs using a wage plus benefits estimate of $55.06 per hour for the PCH Quality Reporting Program.

(d) Patient Engagement/Experience of Care Reporting and Submission Burden

For the Documentation of Goals of Care Discussions Among Cancer Patients measure, PCHs report data through CMS's HQR System on an annual basis during the submission period. We estimate a burden of no more than 10 minutes per PCH per year, as each PCH is required to report one aggregate numerator and denominator for all patients. Using the estimate of 10 minutes (or 0.167 hours) per PCH per year, we estimate a total annual burden of approximately 2 hours across all PCHs (0.167 hours × 11 PCHs) at a cost of $110 (2 hours × $55.06).

(e) eCQM Reporting and Submission Burden

In the FY 2027 IPPS/LTCH PPS final rule, we adopted two measures with voluntary reporting for the CY 2028 reporting period/FY 2030 program year followed by mandatory reporting beginning with the CY 2029 reporting period/FY 2031 program year: the Advance Care

[2] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics: General Medical and Surgical Hospitals, Medical Records Specialists. Accessed December 29, 2025. Available at: *https://www.bls.gov/oes/special-requests/oesm24in4.zip*.

Planning and Malnutrition Care Score eCQMs. Similar to the currently approved information collection burden estimates for submission of eCQMs for the Hospital Inpatient Quality Reporting Program under OMB control number 0938-1022, we assume a Medical Records Specialist will require 10 minutes (0.167 hours) per eCQM to submit the data required per quarter for each PCH, or 40 minutes (0.67 hours) annually. For both eCQMs in the FY 2028 voluntary reporting period/FY 2030 program year, we estimate a total of 80 minutes (1.33 hours) annually per PCH, or 8 hours across 6 PCHs assumed to participate in the voluntary reporting period (1.33 hours x 6 PCHs) at a cost of $440 (8 hours x $55.06). For both eCQMs beginning with the FY 2029 reporting period/FY 2031 program year, we estimate an annual burden of 15 hours across all PCHs (1.33 hours x 11 PCHs) at a cost of $826 (15 hours x $55.06).

(f) Burden Estimate Summary

As shown in Table 3, in summary under OMB control number 0938-1175, we estimate a total burden of 2 hours at a cost of $110 across the 11 PCHs for data collection and submission for the FY 2029 program year. We also estimate a total burden of 17 hours at a cost of $936 across the 11 PCHs for data collection and submission for the FY 2030 program year and subsequent years.

Table 3. Summary of Burden Estimates for the FY 2029 Program Year and Subsequent Years

Information Collection	FY 2029 Program Year	Difference from Currently Approved	FY 2030 Program Year	Difference from Currently Approved	FY 2031 Program Year and Subsequent Years	Difference from Currently Approved
Patient Engagement/Experience of Care Measures	2	0	2	0	2	0
eCQMs	N/A	0	8	+8	15	+15
Claims-Based Measures	N/A	0	N/A	0	N/A	0
Survey-Based Measures	N/A	0	N/A	0	N/A	0
Total Burden Hour Estimate	**2**	**0**	**10**	**+8**	**17**	**+15**
Total Burden Cost Estimate	**$110**	**$0**	**$550**	**+$440**	**$936**	**+$826**

13. Capital Costs (Maintenance of Capital Costs)

We do not estimate any additional capital costs associated with the requirements for patient engagement/experience of care measures for PCHs under the PCH Quality Reporting Program. With regard to administrative costs associated with adoption of eCQMs, we believe they are multifaceted and include not only the burden associated with reporting but also the costs associated with implementing and maintaining program requirements, such as maintaining measure specifications in PCHs' electronic health record systems for the eCQMs used in the PCH Quality Reporting Program.

14. Cost to 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, 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 $10,050,000 annually for the validation and quality reporting contracts. Additionally, this program requires one CMS staff at a GS-13 Step 5 level to operate. GS-13 Step 5 approximate annual salary is $138,024 plus benefits (30%) of $41,407 for a total cost of $179,431. The total annual cost to the Federal Government is $10,229,431.

For most of the claims-based measures, the cost to the Federal Government is minimal. CMS uses data from the CMS National Claims History system that are already being collected for provider reimbursement; therefore, no additional data will need to be submitted by PCHs 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 2029 program year of 2 hours at a cost of $111 as a result of policies finalized in the FY 2026 IPPS/LTCH PPS final rule. Accounting for updated wage rates, the total cost of $111 decreases to $110. For the FY 2030 program year, based on the measure adoptions in the FY 2027 IPPS/LTCH PPS final rule, we estimate a total burden of 17 hours at a cost of $936 (an increase of 15 hours and $826 from our estimate in the FY 2026 IPPS/LTCH PPS final rule) under OMB 0938-1175.

The adoption of the Advance Care Planning and Malnutrition Care Score eCQMs result in an annual burden increase of 15 hours and $826 as shown in Table 3.

16. Publication/Tabulation Dates

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

B. Collection of Information Employing Statistical Methods

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