Supporting Statement – Part A

Collection of Information for the Rural Emergency Hospital (REH) Quality Reporting Program: CY 2027 OPPS/ASC Proposed Rule (OMB# 0938-1454; CMS-10870)

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 publicly reporting on quality-of-care metrics. This information informs consumer decision-making and incentivizes healthcare facilities to make continued improvements.

Specifically, CMS has implemented quality reporting programs for multiple settings, including for rural emergency hospitals (REHs), as authorized by statute, and seeks to achieve its overarching priority to promote improvement, innovation, and modernization of all aspects of quality. Specifically, to better address health care priorities, reduce burden, and increase efficiency: (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.

Information collection requirements through the calendar year (CY) 2028 program determination are currently approved under OMB control number 0938-1454 (expiration date July 31, 2029).[1] This request covers data collection requirements for the CY 2029 program determination and subsequent years.

B.____Justification

1. Need and Legal Basis

Section 125 of Division CC of the Consolidated Appropriations Act (CAA), 2021, established REHs as a new Medicare provider type.

Section 1861(kkk)(7) of the Act requires the Secretary to establish quality measurement reporting requirements for REHs and establish procedures to make the data available to the public on the CMS website. As discussed further in the CY 2024 OPPS/ASC final rule (88 FR 82046 through 82076), CMS finalized policies on certain quality measures and quality reporting requirements for REHs.

Section 1861(kkk)(7)(B)(i) of the Act provides that, with respect to each year beginning with 2023 (or each year beginning on or after the date that is 1 year after one or more measures are first specified under subparagraph (C), a REH shall submit data to the Secretary in accordance with clause (ii). Clause (ii) states that, with respect to each such year, a REH shall submit to the

[1] We are using the phrase "program determination" for the REH Quality Reporting Program to represent our assessment of compliance with program requirements for an applicable year because the REH Quality Reporting Program does not include an associated payment adjustment.

Secretary data in a form and manner, and at a time specified by the Secretary for purposes of this subparagraph.

(a) REH Quality Reporting Program Quality Measures

We recognize REHs will be smaller facilities that can have limited resources compared with larger facilities in metropolitan areas. To reduce burden, consideration is taken to employ data and data collection systems already in place. There are no payment penalties associated with the program; however, similar to the PPS-Exempt Cancer Hospital Quality Reporting Program, REHs are statutorily obligated to report quality measure data.

Publicly reported data on quality-of-care measures as part of the REH Quality Reporting Program are currently submitted via one of three modes: (1) chart-abstracted; (2) claims and other administrative data; and (3) digital, as seen in Table 1.

Chart-abstracted measures rely on information manually abstracted from patient medical records. Because chart abstraction requires manual data collection and entry, these measures typically impose higher burden on hospitals than other types of measures.

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

Measures submitted digitally include electronic clinical quality measures (eCQMs) and those submitted via web-based tools. For eCQMs, information is electronically extracted from electronic health records (EHRs) and/or health information technology (HIT) systems. For measures reported directly to CMS, REHs are required to submit measure data via CMS' Hospital Quality Reporting (HQR) system.

Table 1. Previously Finalized REH Quality Reporting Program Measures for the CY 2028 Program Determination and Subsequent Years

Measure Name
Chart-Abstracted Measures
Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients
Claims-Based Measures
Abdomen Computed Tomography (CT) - Use of Contrast Material
Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery
eCQMs
Emergency Care Access & Timeliness

(b) Summary of Proposed REH Quality Reporting Program Changes

In the CY 2027 OPPS/ASC proposed rule, we did not propose any measure adoptions, removals, or modifications for the REH Quality Reporting Program.

(c) REH Quality Reporting Administrative Program Forms

CMS has implemented procedural requirements that align the hospital, REH, and Ambulatory Surgical Center (ASC) quality reporting programs, which involve submission of certain forms to comply with program requirements or specified program functions. As a result, many of the forms are used for multiple programs and are included under OMB control number 0938-1022 to reduce administrative burden and the potential for errors when updates are made.

The REH Quality Reporting Program uses one administrative form: the Extraordinary Circumstances Exception (ECE) Request form, which offers a process for REHs to request exceptions or extensions to the reporting or required quality data, including eCQM data, for one or more quarters when a REH experiences an extraordinary circumstance not within the control of the REH, such as a cyberattack natural disaster. This form is available online and can be submitted electronically or by fax. This form is completed only on a need-to-use basis and most REHs will not need to complete this form in any given year. Thus, the burden for providers associated with the ECE Request form intended to be utilized in the REH Quality Reporting Program would be nominal, if any. 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.

2. Information Users

CMS uses the submitted data to evaluate the quality of care furnished by participating REHs. The data are analyzed to monitor performance at the individual REH and program levels, and to

assess trends across the healthcare system. These insights inform internal program management, guide oversight activities, and support the development of future quality measurement initiatives. In addition, the data are instrumental in identifying patterns that may signal opportunities for improvement in care delivery, disparities in access or outcomes, or unintended consequences of existing policies.

Participating REHs use the data to track their performance over time and to inform internal quality improvement strategies. CMS facilitates this use by furnishing confidential feedback reports and performance summaries that allow providers to compare their results to national benchmarks and peer group averages. These reports help support continuous quality improvement within organizations and align provider efforts with national healthcare priorities.

Additionally, CMS publicly reports selected quality data through consumer-facing tools such as Medicare Care Compare and other CMS.gov platforms. Public reporting increases transparency, promotes accountability, and empowers patients and caregivers to make informed decisions about their healthcare. It also creates an incentive for providers to improve performance by making comparative data accessible to the broader public.

Beyond operational uses, researchers, healthcare organizations, and policymakers may use aggregate, de-identified data to study trends in healthcare quality and to inform future healthcare delivery reforms. These secondary uses underscore the broader value of the program's data collection efforts in shaping an evidence-based, patient-centered healthcare system.

3. Use of Information Technology

To assist REHs 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 (for example, the automated collection of electronic patient data in EHRs for eCQMs, the free CMS Abstraction and Reporting Tool (CART), for use in collecting data from paper or electronic medical records for chart-abstracted measures), and to increase the utility of the data provided by REHs. CMS also provides a secure data warehouse via the HQR system for storage and transmittal of data. REHs have the option of using authorized vendors to transmit data. CMS has engaged a national support contractor to provide technical assistance with the data collection tool and other program requirements and to provide education to support program participants.

As reflected by the collection and reporting of claims-based quality measures, quality measures submitted via the HQR system, and measures which are derived digitally(for example, eCQMs), 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 the claims-based measures or measures which use data from claims, Medicare Advantage encounter data, and other administrative data in part, this section is not applicable, because these measures can be fully or partially calculated based on data that are already reported to the Medicare program for payment purposes. Therefore, no additional information technology will be required of hospitals to collect these data for these measures.

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect quality of care data for REH care. CMS requires REHs to submit quality measure data for services provided in the REH setting. We prioritize efforts to reduce reporting burden for the collection of quality-of-care information by utilizing electronic data that REHs potentially collect for reporting for accreditation.

5. Small Business

Information collection requirements are designed to allow maximum flexibility to REHs participating in the REH Quality Reporting Program.

The Health Resources and Services 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 rural providers to reduce burden and improve healthcare quality. CMS also provides a help-desk hotline for troubleshooting, and free information available on the QualityNet website through a Questions and Answers function. These activities will assist REHs in gathering information for their own quality improvement efforts and for meeting REH 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 calculation of summary figures to be reliable estimates of REH performance. Frequency of data collection may vary (quarterly, annually, etc.) based on how a quality measure is specified. The following table (Table 2) details the frequency of data submission to CMS by measure type for the REH Quality Reporting Program.

Table 2. Frequency of Data Submission Under the REH Quality Reporting Program by Measure Type

Measure Type	Frequency of Data Submission
Chart-abstracted	Quarterly
eCQM	Annually

Claims-based measures use information derived from Medicare FFS claims data and Medicare Advantage encounter data; REHs submit claims for reimbursement or payment per claims processing timeliness requirements.

7. Special Circumstances

There are no special circumstances for the REH Quality Reporting Program.

8. Federal Register Notice/Outside Consultation

A 60-day Federal Register notice of the CY 2027 OPPS/ASC proposed rule (RIN 0938-AV83, CMS-1850-P) was published on July 07, 2026 (91 FR 41734).

Section 1890A of the Act requires CMS to consider input on the selection of quality and efficiency measures from a multistakeholder group convened by the "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). We refer readers to https://p4qm.org/PRMR/About for more information on the PRMR process.

CMS is additionally supported in this program's efforts by The Joint Commission, Centers for Disease Control and Prevention, Health Resources and Services Administration, and the Agency for Healthcare Research and Quality. These organizations consult with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making collected information accessible, understandable, and relevant to the public. CMS also regularly engages interested parties (for example, solicitation of comments).

9. Payment/Gift to Respondent

The statutory authority for the REH Quality Reporting Program does not require the Secretary to provide incentives for submitting quality measure data under the REH Quality Reporting Program, nor does it require the Secretary to impose penalties for failing to comply with quality reporting program requirements under the REH Quality Reporting Program. No other payments or gifts will be given to REHs 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 REH 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 REH-specific data will be made publicly available as mandated by statute.

Data related to the REH Quality Reporting 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 REH 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 these 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 facility-specific data will be released to the public after REHs 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 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

In the CY 2027 OPPS/ASC proposed rule, we did not propose any measure adoptions, removals, or modifications.

(b) Burden for the CY 2027 Program Determination

Our currently approved burden estimates are based on the 38 REHs acute care and critical access hospital conversions to REH status as of April 11, 2025. Based on the actual number of acute care and critical access hospital conversions to REH status as of April 6, 2026, we estimate that 48 REHs will report data to the REH Quality Reporting Program during the CY 2027 reporting period unless otherwise noted. While the exact number of REHs required to submit data may vary due to status changes to and from an REH, REHs are required by statute to submit quality data. Therefore, for purposes of estimating burden, we assume that all 48 REHs will submit data under the REH Quality Reporting Program for the CY 2027 reporting period and future years.

OMB has currently approved 464 hours under OMB control number 0938-1454, accounting for information collection burden experienced by approximately 38 REHs for the CY 2028 program determination. As shown in Table 2, using our updated assumption of 48 REHs and updated wage rates, we estimate a revised baseline burden of 586 hours at a cost of $33,507 for the CY 2028 program determination. Our burden estimates exclude burden associated with claims-based quality measures, which do not require additional effort or burden from REHs. We also note that any burden related to claims more generally is accounted for under the Health Insurance Common Claims Form and Supporting Regulations under OMB control number 0938-1197 (expiration date October 31, 2027).

Table 2. Total Burden for the CY 2028 Program Determination

Measure Set	*Estimated time per record (minutes) - CY 2028 program determination*	*Number reporting quarters per year - CY 2028 program determination*	*Number of REHs*	*Average number records per REH per quarter*	*Annual burden (hours) per REH*	*Total Burden Hours for CY 2028 program determination*
Chart-Abstracted Measures						
Median Time for Discharged ED Patients	2.9	4	48	63	12.2	586
eCQMs						
Emergency Care Access & Timeliness	10	4	48	1	0.67	0*
Web-Based Measures Subtotal						
Claims-Based Measures	0	0	48	0	0	**0**
Total Burden Hours						**586**
Total Burden @ Medical Records Specialist labor rate ($57.18)						**$33,507**

*REHs have the option to report either the Emergency Care Access & Timeliness eCQM or the Median Time for Discharged ED Patients measure to meet program requirements. Because we are currently unable to estimate the number of REHs that will elect to report the Emergency Care Access & Timeliness eCQM instead of the Median Time for Discharged ED Patients measure, we conservatively include only the higher burden for the Median Time for Discharged ED Patients measure in the total burden summary.

(c) Updated Hourly Wage Rate

The most recent data from the Bureau of Labor Statistics May 2025 National Occupational Employment and Wage Estimates reflects a median hourly wage of $28.59 per hour for medical records specialists working in "general medical and surgical hospitals" (SOC 29-2072).[2] We calculated the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage, consistent with previous years. This is 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 ($28.59 × 2 = $57.18) to estimate total cost is a reasonably accurate estimation method. Accordingly, unless otherwise specified, we will calculate cost burden to REHs using a wage plus benefits estimate of $57.18 per hour throughout the discussion in this section of this rule for the REH Quality Reporting Program.

(d) Chart-Abstracted Measures Burden

For the CY 2027 reporting period/CY 2029 program determination, the chart-abstracted measure set for the REH Quality Reporting Program is comprised of the Median Time from ED Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients) measure.

[2] U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed May 18, 2026. Available at: https://data.bls.gov/oes/#/industry/622100/2025.

REHs have the option to report either the Emergency Care Access & Timeliness eCQM or the Median Time for Discharged ED Patients measure to meet program requirements.

We continue to assume that for chart-abstracted measures where patient-level data are submitted directly to CMS, it will take an estimated 2.9 minutes, or 0.049 hours, per case per measure to collect and submit the data for each submitted case. Further, based on sample size requirements for the similar measure in the Hospital Outpatient Quality Reporting Program, we assume that each REH will abstract and submit data from 63 cases per quarter, for a total of 252 cases per year. Therefore, we estimate that it will take approximately 12.2 hours (0.049 hours x 252 cases) at a cost of approximately $698 per REH (12.2 hours x $57.18) to collect and report data for this measure. Therefore, for all participating REHs, we estimate an annual chart-abstraction burden of 586 hours (12.2 hours x 48 REHs) at a cost of $33,507 (586 hours x $57.18).

(e) eCQM Measures Burden

For the Emergency Care Access & Timeliness eCQM, we assume a Medical Records Specialist will require 10 minutes (0.167 hours) to submit the data required per quarter for each REH, therefore, for each REH that elects to report the Emergency Care Access & Timeliness eCQM, we estimate an annual burden of 40 minutes (0.67 hours; 10 minutes x 4 quarters) annually at a cost of $38 (0.67 hours x $57.18). Because we are currently unable to estimate the number of REHs that will elect to report the Emergency Care Access & Timeliness eCQM instead of the Median Time for Discharged ED Patients measure, we conservatively include only the higher burden for the Median Time for Discharged ED Patients measure in the total burden summary discussed in section 12.h.

(f) Claims-Based Measures Burden

Claims-based measures are derived through analysis of administrative claims data and do not require additional effort or burden on behalf of facilities. As a result, the REH Quality Reporting Program's claims-based measures do not influence our burden calculations.

(g) Total Burden for the CY 2028 Program Determination and Subsequent Years

As shown in Tables 4 and 5, in summary, under OMB control number 0938-1454, we estimate a total annual information collection burden for 48 REHs of 586 hours at a cost of $33,507 for the CY 2029 program determination. The tables below summarize the total burden changes for the CY 2029 program determinations and subsequent years compared to our currently approved information collection burden estimates.

Table 4. Total Burden Hours for the CY 2029 Program Determination and Subsequent Years

Information Collection	CY 2029	Difference from Currently Approved
Chart-Abstracted Measures	586	122
eCQM Measures	0	0
Claims-Based Measures	N/A	0
TOTAL	**586**	**122**

Table 5. Total Burden Dollars for the CY 2029 Program Determination and Subsequent Years

Information Collection	CY 2029	Difference from Currently Approved
Chart-Abstracted Measures	$33,507	$7,959
eCQM Measures	$0	$0
Claims-Based Measures	N/A	$0
TOTAL	**$33,507**	**$7,959**

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs being placed on the REHs. CMS provides a data collection tool and method for submission of data to the participants. There are no additional data submission requirements placing additional cost burdens on REHs.

14. Cost to Federal Government

The cost to the Federal Government for maintaining program activities is for supporting data system architecture, data storage, maintenance and updating of information technology infrastructure on the HQR system secure portal, providing ongoing technical assistance to REHs and data vendors, calculation of claims-based measures, measure development and maintenance, the provision of REHs 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 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 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 REHs for claims-based measures.

15. Program or Burden Changes

We previously requested total annual burden estimates under this OMB control number for the CY 2026 reporting period/CY 2028 program determination of 464 hours at a cost of $25,548 as a result of policies finalized in the CY 2026 OPPS/ASC final rule. Accounting for updated wage rates, the total cost of $25,548 increases to $26,532. For the CY 2027 reporting period/CY 2029 program determination, based on the updated data on the number of REHs, we estimate a total burden of 586 hours at a cost of $33,507 (an increase of 122 hours and $7,959 from our estimate

in the CY 2026 OPPS/ASC final rule for the CY 2026 reporting period/CY 2028 program determination).

16. Publication

As required by the authorizing statute, quality measure data will be made publicly available after providing REHs the opportunity to review their data on data.cms.gov and the Compare tool. The goal of the data collection is to tabulate and publish REH-specific data. CMS will display information on the quality of care provided in the REH setting for public viewing as required by CAA, 2021, beginning in CY 2026. We anticipate updating these data on at least an annual basis. However, in certain circumstances public display may be delayed 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 will become available on the *QualityNet* website (https://qualitynet.cms.gov). We will also display the approved expiration date prominently on the *QualityNet* website's REH 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.

19. Collections of Information Employing Statistical Methods

This information collection does not require the use of statistical methods. However, to reduce burden, facilities may sample using their method of choice to reduce the number of cases for which to submit data.