Supporting Statement – Part A

Submission of Information for the Hospital Inpatient Quality Reporting Program: FY 2027 IPPS/LTCH PPS Final Rule (OMB# 0938-1022, CMS-10210)

A. Background

This is a revision of the currently approved information collection request under OMB control number 0938-1022 (expiration date December 31, 2028). 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 inpatient hospital setting, 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.

The information collection requirements through the FY 2031 payment determination are currently approved under OMB control number 0938-1022. This request covers data collection requirements for the FY 2028 payment determination and subsequent years. This updated information collection request includes changes in burden associated with finalized modifications to the reporting and submission requirements for the Malnutrition Care Score and Hospital Harm eCQMs as well as updated wage rates impacting previously approved burden calculations. We describe additional policies in the FY 2027 IPPS/LTCH final rule in section B.1 that do not change burden.

B. Justification

1. Need and Legal Basis

The Hospital Inpatient Quality Reporting Program was first established to implement Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173), which authorized CMS to pay hospitals that successfully reported quality measures a higher annual update to their payment rates. Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171) revised the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. This is reflected in sections 1886(b)(3)(B)(viii)(I) and (II) of the Social Security Act, which provide that the Annual Payment Update (APU) under the Inpatient Prospective Payment System will be reduced for any subsection (d) hospital that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

Section 1886(o) of the Social Security Act mandates CMS's transition from a passive supplier of health care to an active purchaser of quality care. Pursuant to section 1886(o)(2)(A) of the Social Security Act, CMS must select measures for the Hospital Value-Based Purchasing Program from the measures (other than measures of readmissions) specified under the Hospital Inpatient Quality Reporting Program. Consistent with this legislation, CMS established a Hospital Value-Based Purchasing Program, beginning effective with payment adjustments on FY 2013 discharges, which qualifies hospitals for financial incentives based on their performance on a defined set of quality measures selected for the Hospital Value-Based Purchasing Program from the measures specified under the Hospital Inpatient Quality Reporting Program.

(a) Hospital Inpatient Quality Reporting Program Quality Measures

The FY 2029 APU determination will be based on Hospital Inpatient Quality Reporting Program data reported and supporting forms submitted by hospitals on chart-abstracted measures, patient surveys, and eCQMs for calendar year (CY) 2027 discharges, and data validation for selected hospitals. To reduce burden, CMS uses a variety of different data collection mechanisms and prioritizes data sources and data collection systems that are already in place.

The Hospital Inpatient Quality Reporting Program seeks to collect and publicly report data on quality-of-care metrics for the hospital inpatient setting. Measure data are derived from one of several modes: (1) chart-abstracted; (2) claims and other administrative data; (3) digital; and (4) survey-based and other patient-reported data. See list of currently approved program measures 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.

Digital measures include electronic clinical quality measures (eCQMs), web-based measures, structural measures, process measures, and hybrid measures. For eCQMs, information is electronically extracted from electronic health records (EHRs) and/or health information technology (HIT) systems. For web-based measures, measure data are submitted differently depending on the measure. Four measures are calculated using data submitted to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN): the Influenza Vaccination Coverage Among Healthcare Personnel (HCP) measure, Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations, and Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations, and the Patient Safety Structural measure under OMB control number 0920-0666 (expiration date March 31, 2029). For structural and process measures reported directly to CMS, hospitals are required to submit measure data

via CMS's Hospital Quality Reporting (HQR) system. Hybrid measures use both claims-based data and EHR data. The EHR data consists of a set of core clinical data elements consisting of vital signs, laboratory test information, and patient linking variables collected from hospitals' EHR systems.

Surveys and patient-reported performance outcome measures (PRO-PM) rely on responses to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and requires hospitals to administer the survey and submit the survey data to CMS under OMB control number 0938-0981 (expiration date November 30, 2027). The Hospital-Level Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) PRO-PM uses four sources of data for the calculation of the measure: (1) PRO data; (2) Medicare claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. Hospitals collect the PRO data and responses are submitted electronically through the CMS HQR system. Medicare claims data, enrollment, and beneficiary data, and U.S. Census Bureau survey data are already collected via other mechanisms and do not impose additional burden on hospitals.

Table 1. Currently Approved Hospital Inpatient Quality Reporting Program Measures for the FY 2028 Payment Determination and Subsequent Years

Measure Data Submission Mode and Name
Chart-Abstracted Measures
Severe Sepsis and Septic Shock Management Bundle Measure
Hybrid Measures
Hybrid Hospital-Wide All-Cause Readmission Measure
Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure
eCQMs
Safe Use of Opioids - Concurrent Prescribing
Cesarean Birth
Severe Obstetric Complications
Discharged on Antithrombotic Therapy†
Anticoagulation Therapy for Atrial Fibrillation/Flutter
Antithrombotic Therapy by the End of Hospital Day Two
Venous Thromboembolism Prophylaxis†
Intensive Care Unit Venous Thromboembolism Prophylaxis†
Hospital Harm – Severe Hypoglycemia
Hospital Harm – Severe Hyperglycemia
Hospital Harm – Opioid Related Adverse Events
Hospital Harm – Pressure Injury
Hospital Harm – Acute Kidney Injury
Hospital Harm – Falls With Injury
Hospital Harm – Postoperative Respiratory Failure
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults
Malnutrition Care Score
NHSN Measures

Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations*
Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations*
Influenza Vaccination Coverage Among HCP*
Claims-Based Measures
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA/TKA (COMP-HIP-KNEE)
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke (MORT-30-STK)
Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
Excess Days in Acute Care after Hospitalization for Heart Failure
Excess Days in Acute Care after Hospitalization for Pneumonia
Medicare Spending Per Beneficiary (MSPB)
Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Inpatient Surgical Complications Rate)
Survey-Based Measures
HCAHPS Survey**
Patient-Reported Outcomes-Based Performance Measures
Hospital-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure
Structural Measures
Maternal Morbidity
Age-Friendly Hospital
Patient Safety*

*Burden for these measures is accounted for under OMB control number 0920-0666.
**Burden for this measure is accounted for under OMB control number 0938-0981.
†These measures were finalized for removal beginning with the FY 2030 payment determination in the FY 2027 IPPS/LTCH PPS final rule.

(b) Summary of Finalized Hospital Inpatient Quality Reporting Program Changes

In the FY 2027 IPPS/LTCH PPS final rule, we modified the reporting and submission requirements for eCQMs to require mandatory reporting of the Malnutrition Care Score eCQM beginning with the CY 2028 reporting period/FY 2030 payment determination, and to require mandatory reporting of Hospital Harm eCQMs after two years of self-selected reporting beginning with the CY 2028 reporting period/FY 2030 payment determination.

We also finalized several policies in the FY 2027 IPPS/LTCH PPS final rule which will not affect information collection burden under OMB control number 0938-1022. We adopted three new measures: (1) the Advance Care Planning eCQM beginning with the CY 2028 reporting period/FY 2030 payment determination; (2) the Hospital Harm-Postoperative Venous Thromboembolism (VTE) eCQM beginning with the CY 2028 reporting period/FY 2030 payment determination; and (3) the Excess Days in Acute Care After Hospitalization for Diabetes measure beginning with the July 1, 2025 through June 30, 2027 performance period, associated with the FY 2029 payment determination. We adopted five mortality measures for the

July 1, 2024 through June 30, 2026 performance period, associated with the FY 2028 payment determination, through the July 1, 2027 through June 30, 2029 performance period, associated with the FY 2031 payment determination: (1) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization measure; (2) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization measure; (3) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure; (4) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization measure; and (5) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery measure. Additionally, we modified three measures beginning with the July 1, 2024 through June 30, 2026 performance period, associated with the FY 2028 payment determination: (1) the Excess Days in Acute Care after Hospitalization for AMI measure; (2) the Excess Days in Acute Care after Hospitalization for HF measure; and (3) the Excess Days in Acute Care after Hospitalization for Pneumonia measure. We also removed three self-selected eCQMs beginning with the CY 2028 reporting period/FY 2030 payment determination: (1) the VTE Prophylaxis eCQM; (2) the Intensive Care Unit VTE Prophylaxis eCQM; and (3) Discharged on Antithrombotic Therapy eCQM. Lastly, we updated the reporting and submission requirements for the Maternal Morbidity Structural measure beginning with the CY 2026 reporting period/FY 2028 payment determination.

(c) Hospital Inpatient Quality Reporting Program Administrative Forms

CMS has implemented procedural requirements that align the current quality reporting programs, including the 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, HAC Reduction Program, Hospital Readmissions Reduction Program, End Stage Renal Disease Quality Incentive Program, and the Rural Emergency Hospital Quality Program. These procedural requirements involve submission of forms to comply with hospital quality program requirements. 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 necessary.

The Hospital Inpatient Quality Reporting Program and other current quality reporting programs use fifteen administrative forms. We discuss measure data collection forms in section B.12.o. These forms are used across the ten previously mentioned quality programs. None of these administrative forms are completed on an annual basis; all are on a need-to-use, exception basis and most hospitals will not need to complete any of these forms in any given year, with the exception of the DACA Form, which is completed annually. The burden for providers associated with forms is discussed in section B.12.j.

a. Hospital Inpatient Quality Reporting Notice of Participation

To begin participation in the Hospital Inpatient Quality Reporting Program, subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Social Security Act) paid under the

Inpatient Prospective Payment System (IPPS) must complete a Hospital Inpatient Quality Reporting Notice of Participation Form one time. Other hospitals not paid under the IPPS, such as critical access hospitals (CAHs), may also use this form to give CMS permission to collect and publish data that are voluntarily submitted by a hospital.

Hospitals that indicated their intent to participate using this form will be considered active Hospital Inpatient Quality Reporting Program participants until they submit a withdrawal to CMS. Hospitals that no longer wish to participate in the Hospital Inpatient Quality Reporting Program or those that no longer wish to submit data for publishing on the Compare tool can notify CMS of their decision using the same form discussed above.

We note that the Notice of Participation as well as other forms discussed here and listed in section B.12.o. have been previously approved under OMB control number 0938-1022.

b. Hospital Quality Reporting Data Accuracy and Completeness Acknowledgement (DACA)

Annually, hospitals participating in quality reporting submit the Hospital Quality Reporting DACA form after the end of each reporting year. This form is an acknowledgment that the data a hospital has submitted are complete and accurate.

c. Request Form for Withholding/Footnoting Data for Public Reporting

Hospitals that voluntarily participate in quality reporting but are not paid under the IPPS may elect to have those data withheld from public reporting by completing the Request Form for Withholding/Footnoting Data from Public Reporting. Once the form is submitted, data can be withheld for the quarter in which the form is submitted.

Hospitals statutorily required to participate in the Hospital Inpatient Quality Reporting Program may submit a request to add a footnote to any or all claims-based measure data publicly reported on the Compare tool, or its successor website, if the hospital identifies errors in the claims data.

d. CMS Quality Reporting Program APU Reconsideration Request Form

When CMS determines that a hospital did not meet one or more of the Hospital Inpatient Quality Reporting Program requirement(s) except for validation, the hospital may submit a request for reconsideration to CMS using the CMS Quality Reporting Program APU Reconsideration Request Form by the deadline identified on the Hospital Inpatient Quality Reporting Program APU Notification Letter it received.

e. CMS Hospital Inpatient Quality Reporting Program Validation Review for Reconsideration Request Form

If CMS determines that a hospital did not meet any of the Hospital Inpatient Quality Reporting Program requirements due to a confidence interval validation score of less than 75 percent and the hospital would like to request a reconsideration, the hospital must complete and submit the

CMS Hospital Inpatient Quality Reporting Program Validation Review for Reconsideration Request Form.

f. CMS Quality Program Extraordinary Circumstances Exceptions (ECE) Request Form

CMS offers a process for hospitals to request exceptions or extensions to the reporting of required quality data, including eCQM data, for one or more quarters when a hospital experiences an extraordinary circumstance beyond the hospital's control, 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. In addition, the form indicates that for eCQM reporting circumstances under the Hospital Inpatient Quality Reporting Program and Hospital Outpatient Quality Reporting Program, the request must be submitted by April 1 (for Hospital Inpatient Quality Reporting) or June 15 (Hospital Outpatient Quality Reporting) following the end of a reporting period calendar year.

g. Maternal Morbidity Structural Measure Form

A data collection tool available within the Hospital Quality Reporting system allows hospitals to complete and submit their Maternal Morbidity Structural Measure.

h. Population and Sampling

Each quarter prior to the submission deadline, hospitals must submit aggregate population and sample size counts for chart-abstracted measure sets via the Population and Sampling tool or Extensible Markup Language (XML) file through the Hospital Quality Reporting Secure Portal. These counts include both Medicare and non-Medicare discharges.

i. CMS Quality Reporting Validation Educational Review Form

CMS selects up to 400 subsection (d) hospitals participating in the Hospital Inpatient Quality Reporting Program on an annual basis for data validation (85 FR 58946 and 58948). Specifically, CMS randomly selects up to 200 hospitals for validation and up to 200 hospitals selected using the targeting criteria, applied across eCQMs and chart-abstracted measures.

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

j. Electronic Clinical Quality Measure (eCQM) Denominator Declaration

Hospitals with less than 5 applicable cases for each eCQM are required to attest to those low or no applicable case counts using this form within the Hospital Quality Reporting system.

k. Total Hip Arthroplasty/Total Knee Arthroplasty (THA-TKA) Patient-Reported Outcome-based Performance Measure (PRO-PM)

The THA/TKA PRO-PM requires the collection of pre and post-operative survey data from patients with qualifying THA or TKA procedures. This form is available to hospitals that choose to manually submit their survey data via the Hospital Quality Reporting system.

l. Age Friendly Hospital Structural Measure

A data collection tool available within the Hospital Quality Reporting system allows hospitals to complete and submit the Age Friendly Hospital Structural measure.

m. Hospital Value-Based Purchasing Program Review and Corrections Request Form

We may only select measures for the Hospital Value-Based Purchasing Program from the measures (other than measures of readmissions) specified under the Hospital Inpatient Quality Reporting Program. Hospitals may appeal the calculation of their performance assessment with respect to the performance standards, as well as their Total Performance Score (TPS), for the Hospital Value-Based Purchasing Program. Hospitals may review and request recalculation of their hospital's performance scores on each condition, domain, and TPS using the Hospital Value-Based Purchasing Program Review and Corrections Request Form within 30 calendar days of the posting date of the Value-Based Percentage Payment Summary Report.

n. Hospital Value-Based Purchasing Program Appeal Request Form

CMS has implemented an additional appeal process available to eligible hospitals participating in the Hospital Value-Based Purchasing Program, beyond the existing Review and Corrections process. Hospitals must submit an Appeal Request within 30 calendar days from the date CMS informed the hospital through Hospital Quality Reporting of its decision on the Review and Corrections Request.

o. Hospital Value-Based Purchasing Program Independent CMS Review Request Form

CMS has implemented an independent review that is an additional appeal process available to eligible hospitals participating in the Hospital Value-Based Purchasing Program, beyond the existing Review and Corrections process and Appeal process. Hospitals dissatisfied with the outcome of an Appeal may request an Independent CMS Review. Hospitals are strongly encouraged to request the Independent CMS Review within 30 days after they receive a decision on their Appeal. Hospitals can anticipate a review decision within 90 calendar days following receipt of the Independent CMS Review Request.

2. Information Users

Public reporting of Hospital Inpatient Quality Reporting Program data on Care Compare and the Provider Data Catalog, or their successor websites, enables multiple interested parties to use standardized quality information for quality improvement activities, informed decision making, program operations, and research. Patients and caregivers use the data to compare hospitals and make informed choices about where to seek care. Hospitals and health systems use it to benchmark performance, identify areas for improvement, and monitor trends over time. CMS and other government agencies rely on the data to assess hospital performance, evaluate program effectiveness, and inform policy development. Researchers and analysts access the publicly available datasets, particularly through the Provider Data Catalog, to conduct studies on healthcare quality, outcomes, and other topics of interest. Care Compare primarily presents information in a consumer-friendly format, whereas the Provider Data Catalog provides more detailed, downloadable data to support in-depth analysis.

In addition, CMS will use the information collected from hospital quality reporting to set payment adjustments for value-based purchasing. For example, the Hospital Value-Based Purchasing Program Baseline Measures Report allows hospitals to compare their performance for each measure to the program's benchmarks and achievement thresholds, which are obtained from the scores of all hospitals. These reports allow hospitals time to assess how their current performance in each measure could be scored in the upcoming Hospital Value-Based Purchasing Program payment determinations while there is still time to target improvement activities related to specific measures so that their performance and scores can be maximized.

3. Use of Information Technology

To assist hospitals in participating in standardized data collection initiatives across the industry, CMS continues to improve data collection tools with the dual goals of making data submission easier (for example, the automated collection of electronic patient data in EHRs for eCQMs and hybrid measures, the free CMS Abstraction and Reporting Tool (CART) for use in collecting data from paper or electronic medical records for chart-abstracted measures, or the collection of data from federal registries like the NHSN), and to increase the utility of the data provided by the hospitals. CMS also provides a secure data warehouse via the HQR system for storage and transmittal of data as well as data validation and aggregation services prior to the release of data to the CMS website. Hospitals have the option of using vendors to transmit their 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 digitally-derived (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 hospital inpatient care. CMS requires hospitals to submit quality measure data for services provided in the inpatient setting. We prioritize efforts to reduce reporting burden for the collection of quality of care information by utilizing electronic data that hospitals already collect, as well as aligning eCQMs and related reporting requirements with the Medicare Promoting Interoperability Program for Eligible Hospitals and CAHs.

5. Small Business

Information collection requirements are designed to allow maximum flexibility specifically to small hospitals wishing to participate in hospital reporting. This effort will assist small hospitals in gathering information for their own quality improvement efforts. We define a "small hospital" as one with 1-99 inpatient beds. Approximately 886 small IPPS hospitals and 15 small hospitals located in Maryland or Puerto Rico participated in the Hospital Inpatient Quality Reporting Program for the FY 2027 payment determination. In addition, as defined under 42 CFR Part 485 subpart F, a CAH (referred to as a non-IPPS hospital under the Hospital Inpatient Quality Reporting Program) may have no more than 25 inpatient beds. We estimate approximately 1,400 CAHs could voluntarily participate in the Hospital Inpatient Quality Reporting Program; therefore, we assume all 1,400 CAHs hospitals would qualify as small hospitals. As a result, we estimate a total of 2,301 small hospitals (886 IPPS + 15 Maryland/Puerto Rico + 1,400 CAHs) will submit data for the Hospital Inpatient Quality Reporting Program for the CY 2026 reporting period.

The Health Resources & Services Administration's Medicare Rural Hospital Flexibility Program (Flex) and Medicare Beneficiary Quality Improvement Project, as well as CMS's QIOs, provide technical assistance to small and rural hospitals 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 small hospitals in gathering information for their quality improvement efforts and for meeting Hospital Inpatient 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 data validation and calculation of summary figures to be reliable estimates of hospital performance. Frequency of data collection may vary (monthly, quarterly, annually, etc.) based on how a quality measure is specified. The following table details the frequency of data submission to CMS by measure type.

Table 2. Frequency of Data Submission by Measure Type

Measure Type	Frequency of Data Submission
Chart-abstracted	Quarterly
Structural measures	Annually
Survey measures	Quarterly
NHSN (other than CAUTI and CLABSI Standardized Infection Ratio Stratified for Oncology Locations measures) and EHR-based (for example, eCQMs, hybrid measures)	Annually
CAUTI and CLABSI Standardized Infection Ratio Stratified for Oncology Locations measures	Quarterly
Patient Reported Outcome-Performance Measures	Semi-annually
Electronic Clinical Quality measures; Electronic Health Record elements of Hybrid measures	Annually

Claims-based measures use information derived from Medicare FFS claims data and Medicare Advantage encounter data; hospitals submit claims for reimbursement or payment per claims processing timeliness requirements. In addition, the NHSN web-based measure collected by the CDC is submitted for at least one self-selected week during each month of the reporting quarter. To collect these 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

A 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 Hospital Inpatient Quality Reporting Program are required by statute to undergo a recognized consensus process. Section 1890(b) of the Social Security 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 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-MSR for more information on the PRMR process.

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

9. Payment/Gift to Respondent

Hospitals are required to submit these data in order to receive the full APU. No other payments or gifts will be given to hospitals 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 Hospital Inpatient 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 QIOs confidentiality requirements, which can be found at 42 C.F.R. Part 480. In addition, the tools used for transmission of data are considered confidential forms of communication, and there are safeguards in place in accordance with HIPAA Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. Only hospital-specific data will be made publicly available as mandated by statute.

Data related to the Hospital Inpatient 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 in use for quality programs including the Hospital Inpatient 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 hospital-specific data will be released to the public after hospitals have had an opportunity to review the data that are to be made public with respect to the hospital, 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

In the FY 2027 IPPS/LTCH PPS final rule, we modified the reporting and submission requirements for eCQMs to require mandatory reporting of the Malnutrition Care Score eCQM beginning with the CY 2028 reporting period/FY 2030 payment determination, and to require mandatory reporting of Hospital Harm eCQMs after two years of self-selected reporting beginning with the CY 2028 reporting period/FY 2030 payment determination.

We discuss other policies finalized in the FY 2027 IPPS/LTCH PPS final rule which will not affect information collection burden under OMB control number 0938-1022 in section B.1.b.

(b) Burden for the FY 2028 Payment Determination

Our currently approved burden estimates are based on an assumption of approximately 3,050 IPPS hospitals and 1,500 non-IPPS hospitals. Based on data from the FY 2026 Hospital Inpatient Quality Reporting Program payment determination, we are maintaining that assumption. For the purposes of burden estimation, we assume all activities associated with the Hospital Inpatient 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 chart-abstraction of patient data from medical records, the submission of electronic data from EHRs, the submission of data to clinical registries, and the completion of any of the other applicable forms associated with activities related to the Hospital Inpatient Quality Reporting Program.

OMB has currently approved 1,351,632 hours at a cost of approximately $73.7 million under OMB control number 0938-1022, accounting for information collection burden experienced by approximately 3,050 IPPS hospitals and 1,500 non-IPPS hospitals for the FY 2028 payment determination. As shown in Table 3, using updated wage rates and adjusting for rounding, we estimate a revised baseline burden of 1,351,631 hours at a cost of $73.3 million for the FY 2028 payment determination. As previously stated, our burden estimates exclude burden associated with the NHSN under OMB control number 0920-0666 (expiration date March 31, 2029), the HCAHPS Survey measure under OMB control number 0938-0981 (expiration date November 30, 2027), and the Health Insurance Common Claims Form and Supporting Regulations under OMB control number 0938-1197 (expiration date October 31, 2027).

Table 3. Currently Approved Burden Estimates for the Hospital Inpatient Quality Reporting Program Measure Set and Other Activities for the FY 2028 Payment Determination

Measure Set	*Estimated time per record (minutes) - FY 2028 payment determination*	*Number reporting quarters per year - FY 2028 payment determination*	*Number of respondents*	*Average number records per hospital per quarter*	*Annual burden (hours) per hospital*	*Total Burden Hours for FY 2028 payment determination*
CHART ABSTRACTION						
IPPS Hospitals (3,050)						
Sepsis measure	60	4	3,050	100	400	1,220,000
Non-IPPS Hospitals (1,500)						
Sepsis measure	60	4	362	25	100	36,200
Chart Abstracted Measure Subtotal (IPPS and Non-IPPS)						**1,256,200**
HYBRID MEASURES						
IPPS Hospitals (3,050)						
Hybrid HWR measure	10	4	3,050	1	0.67	2,033
Hybrid HWM Measure	10	4	3,050	1	0.67	2,033
Non-IPPS Hospitals (1,500)						
Hybrid HWR measure	10	4	1,500	1	0.67	1,000
Hybrid HWM measure	10	4	1,500	1	0.67	1,000
Hybrid Measure Subtotal (IPPS and Non-IPPS)						**6,067**
STRUCTURAL MEASURES						
IPPS Hospitals (3,050)						
Maternal Morbidity measure	5	1	3,050	1	0.083	254
Age Friendly Hospital measure	10	1	3,050	1	0.167	508
Non-IPPS Hospitals (1,500)						
Maternal Morbidity measure	5	1	1,500	1	0.083	125
Age Friendly Hospital measure	10	1	1,500	1	0.167	250
Structural Measure Subtotal (IPPS and Non-IPPS)						**1,137**
REPORTING eCQMs						
IPPS Hospitals (3,050)						
Reporting 8 eCQMs	80	4	3,050	1	5.33	16,267

Login and Run Software for Excessive Radiation Dose eCQM	15	1	3,050	1	0.25	763
Non-IPPS Hospitals (1,500)						
Reporting 8 eCQMs	80	4	1,500	1	5.33	8,000
Login and Run Software for Excessive Radiation Dose eCQM	15	1	1,500	1	0.25	375
eCQM Subtotal (IPPS and Non-IPPS)						**25,405**
PRO-PM MEASURES						
IPPS Hospitals (3,050)						
THA/TKA PRO-PM measure (Survey)	7.25	N/A	330,000	N/A	8.76	39,875
THA/TKA PRO-PM measure (Reporting)	10	1	3,050	1	0.33	1,017
Non-IPPS Hospitals (1,500)						
THA/TKA PRO-PM measure (Survey)	7.25	N/A	*	N/A	8.76	*
THA/TKA PRO-PM measure (Reporting; Mandatory)	10	1	1,500	1	0.33	500
PRO-PM Measures Subtotal						**41,392**
OTHER ACTIVITIES **All Hospitals (3,050 IPPS + 1,500 Non-IPPS)**						
Population and sampling for the ongoing measure sets	15	4	4,550	4	4	18,200
eCQM Validation	10	4	400	8	5.33	2,133
All other forms used in the data collection process	14.5	1	4,550	1	0.25	1,098
Subtotal other activities						**21,431**
Total Burden Hours						**1,351,631**
Total Burden for Surveys @ Average Individual Labor rate (39,875 hours x $25.89/hr)						**$1,032,364**
Total Burden @ Medical Records Specialist labor rate (1,311,757 hours x $55.06/hr)						**$72,225,304**
Total Burden						**$73,257,667**

* We are not able to accurately distinguish the number of Hospital-Level THA/TKA procedures that take place in IPPS hospitals from those conducted in non-IPPS hospitals. As a result, we combine the IPPS and non-IPPS hospital burden associated with completion of the pre-operative and post-operative surveys.

Changes to currently approved burden estimates due to policies finalized in the FY 2027 IPPS/LTCH PPS final rule are discussed below.

(c) Updated Hourly Wage Rates

Using the most recent data from the BLS for medical records specialists (SOC 29-2072), entitled, the May 2024 National Occupational Employment and Wage Estimates (OEWS), we use the

median hourly wage for medical records specialists for the industry, "general medical and surgical hospitals," which is $27.53.[1] We believe the industry of "general medical and surgical hospitals" is more specific to our settings for use in our calculations than other industries that fall under medical records specialists, such as "office of physicians" or "nursing care facilities." We calculate the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage, consistent with previous years. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly by employer and methods of estimating these costs vary widely in the literature. Nonetheless, we believe that doubling the hourly wage rate ($27.53 × 2 = $55.06) to estimate total cost is a reasonably accurate estimation method. Accordingly, we calculate cost burden to hospitals using a wage plus benefits estimate of $55.06 per hour for the Hospital Inpatient Quality Reporting Program.

We calculate the cost for beneficiaries undertaking administrative and other tasks on their own time to be a post-tax wage of $25.89/hr. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices identifies the approach for valuing time when individuals undertake activities on their own time.[2] To derive the costs for beneficiaries, a measurement of the usual weekly earnings of wage and salary workers of $1,204, divided by 40 hours to calculate an hourly pre-tax wage rate of $30.10/hr.[3] This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 14 percent calculated by comparing pre- and post-tax income,[4] resulting in the post-tax hourly wage rate of $25.89/hr. Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

(d) Chart-Abstracted Measure Reporting and Submission Burden

As shown in Table 3 for the FY 2028 payment determination, we currently estimate the information collection burden associated with the reporting of chart-abstracted measures to be 60 minutes or 1 hour per record for the Severe Sepsis and Septic Shock: Management Bundle measure. We continue to assume that each IPPS hospital will report 100 records quarterly for a total annual burden of 400 hours (1 hour/record x 100 records x 4 quarters) per IPPS hospital. We estimate an annual burden of 1,220,000 hours (400 hours/hospital x 3,050 IPPS hospitals) at a cost of $67,173,200 (1,220,000 hours x $55.06) across all IPPS hospitals. We also estimate an annual burden of 36,200 hours (100 hours/hospital x 362 non-IPPS hospitals) at a cost of $1,993,172 (36,200 hours x $55.06) across all participating non-IPPS hospitals.

---

[1] 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*.

[2] https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework. Office of the Assistant Secretary for Planning an Evaluation, Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices, September 17, 2017. Available at https://aspe.hhs.gov/reports/valuing-time-us-departmenthealth-human-services-regulatory-impact-analysesconceptual-framework.

[3] Bureau of Labor and Statistics, Usual Weekly Earnings of Wage and Salary Workers, 2025. Available at https://www.bls.gov/news.release/pdf/wkyeng.pdf. Accessed February 18, 2026.

[4] U.S. Census Bureau, Income in the United States: 2024, p. 42, September 2025. Available at https://www2.census.gov/library/publications/2025/demo/p60-286.pdf.

(e) eCQM Reporting and Submission Burden

For eCQMs, only the time associated with electronically submitting data to CMS is accounted for in our burden estimates because patient data are already entered into EHRs and HITs as part of clinical practice. In the FY 2027 IPPS/LTCH PPS final rule, we adopted two new eCQMs that will be available for hospitals to self-select to report beginning with the CY 2028 reporting period/FY 2030 payment determination: (1) the Advance Care Planning eCQM and (2) the Hospital Harm-Postoperative VTE eCQM. We also modified the reporting and submission requirements for eCQMs to require mandatory reporting of the Malnutrition Care Score eCQM beginning with the CY 2028 reporting period/FY 2030 payment determination, and to require mandatory reporting of Hospital Harm eCQMs after two years of self-selected reporting beginning with the CY 2028 reporting period/FY 2030 payment determination. In the currently approved eCQM measure set, there are two Hospital Harm eCQMs from which hospitals can self-select: Hospital Harm-Falls with Injury and Hospital Harm-Postoperative Respiratory Failure. Under this policy, these two measures will begin mandatory reporting with the CY 2028 reporting period/FY 2030 payment determination, because they were adopted in the FY 2025 IPPS/LTCH PPS final rule for self-selection eCQMs beginning with the CY 2026 reporting period/FY 2028 payment determination (89 FR 69534 through 69545). Lastly, we removed three eCQMs available for hospitals to self-select to report beginning with the CY 2028 reporting period/FY 2030 payment determination: (1) the VTE Prophylaxis eCQM; (2) the Intensive Care Unit VTE eCQM; and (3) Discharged on Antithrombotic Therapy eCQM.

For the CY 2026 reporting period/FY 2028 payment determination, hospitals are required to submit data for eight total eCQMs: three self-selected and the Safe Use of Opioids-Concurrent Prescribing, Severe Obstetric Complications, Cesarean Birth, Hospital Harm - Severe Hypoglycemia, and Hospital Harm - Severe Hyperglycemia eCQMs. For the CY 2027 reporting period/FY 2029 payment determination, hospitals are required to submit data for these eight eCQMs in addition to the Hospital Harm - Opioid-Related Adverse Events eCQM. For the CY 2028 reporting period/FY 2030 payment determination and CY 2029 reporting period/FY 2031 payment determination, hospitals will be required to submit data for these nine eCQMs as well as the Hospital Harm – Pressure Injury, Hospital Harm – Acute Kidney Injury, Malnutrition Care Score, Hospital Harm – Falls with Injury, and Hospital Harm – Postoperative Respiratory Failure eCQMs, for a total of 14 eCQMs. Beginning with the CY 2030 reporting period/FY 2032 payment determination, hospitals will be required to submit data for these 14 eCQMs as well as the Hospital Harm – Postoperative VTE eCQM, for a total of 15 eCQMs.

We continue to estimate the information collection burden associated with the eCQM reporting and submission requirements to be 10 minutes per measure per quarter of eCQM data. For the CY 2026 reporting period/FY 2028 payment determination, we estimate a total of 80 minutes or 1.33 hours (10 minutes × 8 eCQMs) per hospital per quarter of eCQM data. We estimate a total burden across all participating IPPS hospitals of 16,267 hours (1.33 hours × 3,050 IPPS hospitals × 4 quarters) at a cost of $895,661 (16,267 hours × $55.06). We also estimate a total burden of 8,000 hours (1.33 hours x 1,500 non-IPPS hospitals x 4 quarters) at a cost of $440,480 (8,000 hours × $55.06) for reporting four quarters of eCQM data for all non-IPPS hospitals.

For the CY 2027 reporting period/FY 2029 payment determination, we estimate a total of 90 minutes or 1.5 hours (10 minutes × 9 eCQMs) per hospital per quarter of eCQM data. We estimate a total burden of across all participating IPPS hospitals of 18,300 hours (1.5 hours x 3,050 IPPS hospitals × 4 quarters) at a cost of $1,007,598 (18,300 hours × $55.06). We also estimate a total burden of 9,000 hours (1.5 hours × 1,500 non-IPPS hospitals x 4 quarters) at a cost of $495,540 (9,000 hours × $55.06) for reporting four quarters of eCQM data for all non-IPPS hospitals.

For the CY 2028 reporting period/FY 2030 payment determination and CY 2029 reporting period/FY 2031 payment determination, we estimate a total of 140 minutes or 2.33 hours (10 minutes × 14 eCQMs) per hospital per quarter of eCQM data. We estimate a total burden across all participating IPPS hospitals of 28,467 hours annually (2.33 hours × 3,050 IPPS hospitals x 4 quarters) at a cost of $1,567,393 (28,467 hours × $55.06). We also estimate a total burden of 14,000 hours annually (2.33 hours x 1,500 non-IPPS hospitals × 4 quarters) at a cost of $770,840 (14,000 hours × $55.06) for reporting four quarters of eCQM data for all non-IPPS hospitals.

For the CY 2030 reporting period/FY 2032 payment determination and subsequent years, we estimate a total of 150 minutes or 2.5 hours (10 minutes × 15 eCQMs) per hospital per quarter of eCQM data. We estimate a total burden across all participating IPPS hospitals of 30,500 hours annually (2.5 hours × 3,050 IPPS hospitals x 4 quarters) at a cost of $1,679,330 (30,500 hours × $55.06). We also estimate a total burden of 15,000 hours annually (2.5 hours × 1,500 non-IPPS hospitals × 4 quarters) at a cost of $825,900 (15,000 hours × $55.06) for reporting four quarters of eCQM data for all non-IPPS hospitals.

For the Excessive Radiation Dose eCQM, hospitals use software to convert images within their EHR into intermediate data elements. Hospitals can use the free Alara Imaging Software for CMS Measure Compliance or similar software. For the Alara Imaging Software, hospitals log in through the measure developer's secure portal and run the software inside their firewall. The software runs automatically to create the three intermediate data elements needed for the measure. Once the software finishes creating these intermediate variables, hospitals can send the data to their EHR for measure calculation and reporting. The software allows additional options such as the ability to send the data to other business associates, such as vendors, if needed. No manual data entry is required. While this eCQM is not mandatory but is instead an eCQM available for hospitals to self-select, for estimating purposes we assume all hospitals will report this eCQM. In future years when we have data on the number of hospitals electing to report this eCQM, we may update our estimate at that time. We estimate that each hospital will spend approximately 15 minutes (0.25 hours) annually to conduct these activities prior to data submission and therefore estimate a total annual burden of 763 hours (0.25 hours x 3,050 hospitals) at a cost of $41,983 (763 hours x $55.06) for all IPPS hospitals. We also estimated a total annual burden of 375 hours (0.25 hours x 1,500 hospitals) at a cost of $20,648 (375 hours x $55.06) for all non-IPPS hospitals.

Based on the calculations discussed in this section, we estimate a total burden for reporting of eCQMs for the CY 2026 reporting period/FY 2028 payment determination of 25,405 hours (16,267 + 8,000 + 763 + 375) at a cost of $1,398,772 ($895,661 + $440,480 + $41,983 + $20,648). For the CY 2027 reporting period/FY 2029 payment determination, we estimate a total

burden of 28,438 hours (18,300 + 9,000 + 763 + 375) at a cost of $1,565,769 ($1,007,598 + $495,540 + $41,983 + $20,648). For the CY 2028 reporting period/FY 2030 payment determination and CY 2029 reporting period/FY 2031 payment determination, we estimate a total burden of 43,605 hours (28,467 + 14,000 + 763 + 375) at a cost of $2,400,864 ($1,567,393 + $770,840 + $41,983 + $20,648). For the CY 2030 reporting period/FY 2032 payment determination and subsequent years, we estimate a total annual burden of 46,638 hours (30,500 + 15,000 + 763 + 375) at a cost of $2,567,861 ($1,679,330 + $825,900 + $41,983 + $20,648).

Table 4. Estimated Burden for the eCQM Reporting and Submission Requirements for the FY 2028 Payment Determination and Subsequent Years

eCQM Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 2028 Payment Determination						
Reporting 8 eCQMs (IPPS Hospitals)	80	4	3,050	1	5.33	16,267
Reporting 8 eCQMs (Non-IPPS Hospitals)	80	4	1,500	1	5.33	8,000
Login and Run Software for Excessive Radiation Dose eCQM (IPPS Hospitals)	15	1	3,050	1	0.25	763
Login and Run Software for Excessive Radiation Dose eCQM (Non-IPPS Hospitals)	15	1	1,500	1	0.25	375
Total Burden Hours						**25,405**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$1,398,772**
FY 2029 Payment Determination						
Reporting 9 eCQMs (IPPS Hospitals)	90	4	3,050	1	6	18,300
Reporting 9 eCQMs (Non-IPPS Hospitals)	90	4	1,500	1	6	9,000
Login and Run Software for Excessive Radiation Dose eCQM (IPPS Hospitals)	15	1	3,050	1	0.25	763
Login and Run Software for Excessive Radiation Dose eCQM (Non-	15	1	1,500	1	0.25	375

IPPS Hospitals)						
Total Burden Hours						**28,438**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$1,565,769**
FY 2030 and FY 2031 Payment Determination						
Reporting 14 eCQMs (IPPS Hospitals)	140	4	3,050	1	9.33	28,467
Reporting 14 eCQMs (Non-IPPS Hospitals)	140	4	1,500	1	9.33	14,000
Login and Run Software for Excessive Radiation Dose eCQM (IPPS Hospitals)	15	1	3,050	1	0.25	763
Login and Run Software for Excessive Radiation Dose eCQM (Non-IPPS Hospitals)	15	1	1,500	1	0.25	375
Total Burden Hours						**43,605**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$2,400,864**
FY 2032 Payment Determination						
Reporting 15 eCQMs (IPPS Hospitals)	150	4	3,050	1	10	30,500
Reporting 15 eCQMs (Non-IPPS Hospitals)	150	4	1,500	1	10	15,000
Login and Run Software for Excessive Radiation Dose eCQM (IPPS Hospitals)	15	1	3,050	1	0.25	763
Login and Run Software for Excessive Radiation Dose eCQM (Non-IPPS Hospitals)	15	1	1,500	1	0.25	375
Total Burden Hours						**46,638**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$2,567,861**

(f) Structural Measure Reporting and Submission Burden

We did not finalize any changes to the reporting or submission requirements for the Age Friendly Hospital measure in the FY 2027 IPPS/LTCH PPS final rule.

Reporting on the Age Friendly Hospital measure involves each hospital providing responses and attesting “yes” or “no” in response to a total of five domains annually during the submission period for a given reporting period through CMS’s HQR System. We estimate an annual burden of 508 hours across all IPPS hospitals (0.167 hours × 3,050 IPPS hospitals) at a cost of $27,989 (508 hours × $55.06) and an annual burden of 250 hours across all non-IPPS hospitals (0.167 hours × 1,500 non-IPPS hospitals) at a cost of $13,765 (250 hours × $55.06).

As shown in Table 3 for the FY 2027 payment determination, we currently estimate the information collection burden associated with the reporting of the Maternal Morbidity and Age Friendly Hospital measures to be 5 minutes (0.083 hours) and 10 minutes (0.167 hours) per hospital per year, respectively.

Reporting on the Maternal Morbidity Structural measure involves each hospital responding to a single question using a web-based tool available via CMS's HQR System with one of the following response options: (A) "Yes"; (B) "No"; or (C) "N/A (our hospital does not provide inpatient labor/delivery care)." Hospitals are required to submit responses for this structural measure on an annual basis during the submission period. In the FY 2027 IPPS/LTCH PPS final rule, we modified the reporting and submission requirements for the Maternal Morbidity measure beginning with the CY 2026 reporting period/FY 2028 payment determination. We updated the measure to add a sub-question to collect the name of the Statewide and/or National Perinatal Quality Improvement Collaborative Program in which the hospital participates. We believe that the currently approved burden of five minutes is adequate for hospitals to both attest to the current two-part question and answer the updated sub-question and therefore are not finalizing any changes to the currently approved burden estimate. We estimate an annual burden of 254 hours across all IPPS hospitals (0.083 hours × 3,050 IPPS hospitals) at a cost of $13,985 (254 hours × $55.06) and an annual burden estimate of 125 hours across all non-IPPS hospitals (0.083 hours x 1,500 non-IPPS hospitals) at a cost of $6,883 (125 hours x $55.06).

As previously stated, the burden associated with the Patient Safety Structural measure is collected via the NHSN under OMB control number 0920-0666.

Table 5. Estimated Burden for Structural Measure Reporting for the FY 2028 Payment Determination and Subsequent Years

Structural Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 2028 Payment Determination and Subsequent Years						
Maternal Morbidity measure (IPPS Hospitals)	5	1	3,050	1	0.083	254
Maternal Morbidity measure (Non-IPPS Hospitals)	5	1	1,500	1	0.083	125
Subtotal Burden Hours						**379**
Age Friendly Hospital measure (IPPS Hospitals)	10	1	3,050	1	0.167	508
Age Friendly Hospital measure (Non-IPPS Hospitals)	10	1	1,500	1	0.167	250

Subtotal Burden Hours	**758**
Total Burden Hours	**1,137**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)	**$62,622**

(g) Hybrid Measure Reporting and Submission Burden

We do not expect any additional burden to hospitals to report the claims-based portion of these measures because these data are already reported to the Medicare program for payment purposes. However, we do expect that hospitals will experience burden in reporting the EHR data.

We did not make changes to the reporting or submission requirements for hybrid measures in the FY 2027 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2028 payment determination, we currently estimate the information collection burden associated with the reporting of hybrid measures to be 10 minutes (0.167 hours) per measure per quarter for each hospital or 80 minutes (1.33 hours) for both measures annually (10 minutes x 2 measures x 4 quarters). The Hybrid HWR and Hybrid HWM measures use both claims-based data and EHR data, specifically, a set of core clinical data elements consisting of vital signs and laboratory test information and patient linking variables collected from hospitals' EHR systems. We do not estimate any burden to hospitals to report the claims-based portion of these measures because these data are already reported to the Medicare program for payment purposes. However, we do expect that hospitals will experience burden in reporting the EHR data.

We estimate the annual burden for all 3,050 IPPS hospitals to be 4,067 hours (1.33 hours/hospital x 3,050 IPPS hospitals) at a cost of $223,911 (4,067 hours x $55.06). The total annual burden for all 1,500 non-IPPS hospitals is estimated to be 2,000 hours (1.33 hours/hospital x 1,500 non-IPPS hospitals) at a cost of $110,120 (2,000 hours x $55.06).

Table 6. Estimated Burden for Hybrid Measure Reporting and Submission Requirements for the FY 2028 Payment Determination and Subsequent Years

Hybrid Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 2028 Payment Determination and Subsequent Years						
Hybrid HWR measure (IPPS Hospitals)	10	4	3,050	1	0.67	2,033
Hybrid HWR measure (Non-IPPS Hospitals)	10	4	1,500	1	0.67	1,000
Subtotal Burden Hours						**3,033**
Hybrid HWM measure (IPPS Hospitals)	10	4	3,050	1	0.67	2,033

Hybrid HWM measure (Non-IPPS Hospitals)	10	4	1,500	1	0.67	1,000
Subtotal Burden Hours						**3,033**
Total Burden Hours						**6,067**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$334,031**

(h) Patient-Reported Outcomes-Based Performance Measure Reporting and Submission Burden

We did not make changes to the reporting or submission requirements for PRO-PM measures in the FY 2027 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2028 payment determination, we continue to estimate the burden per respondent to complete the pre-operative and post-operative questionnaires is 7.25 minutes (0.121 hours). For the data submission which is reported via the HQR System, we continue to estimate a burden of 10 minutes (0.167 hours) per response.

The Hospital-Level THA/TKA PRO-PM uses four sources of data for the calculation of the measure: (1) PRO data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. We estimate no additional burden associated with claims data, Medicare enrollment and beneficiary data, and U.S. Census Bureau survey data as these data are already collected via other mechanisms.

Hospitals have multiple options for when and how they collect PRO data so they can best determine the mode and timing of collection that works best for their patient population. The possible patient touchpoints for pre-operative PRO data collection include the doctor's office, pre-surgical steps such as education classes, or medical evaluations that can occur in an office or at the hospital. The modes of PRO data collection can include completion of the pre-operative surveys using electronic devices (such as an iPad or tablet), pen and paper, mail, phone call, or through the patient's portal. Post-operative PRO data collection modes are similar to pre-operative modes. The possible patient touchpoints for post-operative data collection can occur before the follow-up appointment, at the doctor's office, or after the follow-up appointment. The potential modes of PRO data collection for post-operative data are the same as for pre-operative data. If the patient does not or cannot attend a follow-up appointment, the modes of collection can include completion of the post-operative survey using email, mail, phone, or through the patient portal. Use of multiple modes can increase response rates as it allows for different patient preferences. Participating hospitals need to submit data twice (pre-operative data and post-operative data).

For burden estimation purposes, we assume that most hospitals will likely undertake PRO data collection through a screening tool incorporated into their EHR or other patient intake process. We estimate that approximately 330,000 THA/TKA procedures occur in the inpatient setting each year, and that many patients could complete both the pre-operative and post-operative questionnaires, although from our experience with using this measure in the Comprehensive Joint Replacement model, we are also aware that not all patients who complete the pre-operative questionnaire would complete the post-operative questionnaire. We are not able to accurately distinguish the number of procedures that take place in IPPS hospitals from those conducted in

non-IPPS hospitals. As a result, we combine the burden associated with completion of the pre-operative and post-operative surveys. For the FY 2028 payment determination and subsequent years, we estimate a total of 39,875 hours (330,000 patients x 0.121 hours) at a cost of $1,032,364 (39,875 hours x $25.89) across all IPPS and non-IPPS hospitals.

With regard to the burden for hospitals to submit measure data, for the FY 2028 payment determination and subsequent years, we estimate a total annual burden of 1,017 hours (0.33 hours x 3,050 IPPS hospitals) at a cost of $55,996 (1,017 hours x $55.06) for all IPPS hospitals and a total annual burden of 500 hours (0.33 hours x 1,500 non-IPPS hospitals) at a cost of $27,530 (500 hours x $55.06).

Table 7. Estimated Burden for PRO-PM Measure Reporting and Submission Requirements for the FY 2028 Payment Determination and Subsequent Years

PRO-PM Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of respondents***	***Average number records per respondent per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all respondents***
FY 2028 Payment Determination and Subsequent Years						
IPPS and Non-IPPS Hospitals (Survey)	7.25	N/A	330,000	N/A	8.76	39,875
IPPS Hospitals (Reporting)	10	2	3,050	1	0.33	1,017
Non-IPPS Hospitals (Reporting)	10	2	1,500	1	0.33	500
Total Burden Hours						**41,392**
Total Burden @ Average Individual labor rate ($25.89/hr)						**$1,032,364**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$83,526**

(i) Burden for Validation of Hospital Inpatient Quality Reporting Program Measure Data and Population and Sampling for Ongoing Measure Sets

We did not make any changes to the information collection requirements for eCQM validation or population and sampling of ongoing measure sets in the FY 2027 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2028 payment determination, we continue to estimate the information collection burden associated with eCQM validation for CY 2024 reporting period/FY 2027 payment determination and subsequent years to be 10 minutes (0.167 hours) per record for the pool of 400 hospitals selected and assume each selected hospital will submit 8 cases each year. We also continue to estimate the information collection burden associated with population and sampling of ongoing measure sets to be 15 minutes (0.25 hours) per record per quarter and assume each hospital will report four records for four quarters each year.

We estimate the information collection burden per hospital associated with eCQM validation of CY 2024 data impacting the FY 2027 payment determination and for subsequent years to be 2,133 hours across the 400 IPPS hospitals selected for eCQM validation (0.167 hours × 4 quarters × 8 cases × 400 IPPS hospitals) at a cost of $117,461 (2,133 hours x $55.06).

We estimate the information collection burden per hospital associated with population and sampling of ongoing measure sets to be 4 hours (15 minutes/record/quarter x 4 records x 4 quarters). For all 4,550 IPPS and non-IPPS hospitals, we estimate a total annual burden of 18,200 hours (4 hours x 4,550 hospitals) at a cost of $1,002,092 (18,200 hours x $55.06).

(j) Burden Associated with Completion of Forms

Time estimates for activities other than chart-abstraction, including completion of the forms listed in section B.1.b., routine reporting of population and sampling numbers for ongoing chart-abstracted measures, and review of reports were made in consultation with our Hospital Inpatient Quality Reporting Program support contractor, which is responsible for routine interface with hospitals and QIOs regarding Hospital Inpatient Quality Reporting Program requirements. We define "all other forms used in the data collection process" as the forms listed below. As shown in Table 3 and consistent with estimates in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49762), we continue to estimate a burden of 15 minutes (0.25 hours) per hospital to complete applicable forms.

Other than the DACA form, the forms listed in section B.1.b. would not be filled out by hospitals on a regular basis. Because the CMS Quality Reporting Program ECE Request Form would be used across eleven 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, HAC Reduction Program, Hospital Readmissions Reduction Program, Rural Emergency Hospital Quality Reporting Program, and End Stage Renal Disease Quality Incentive 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 in the event of an extraordinary circumstance or disaster if they seek an exception from data reporting requirements due to such extraordinary circumstance. For example, in CY 2023, 195 ECE requests were submitted by hospitals for an exception from reporting requirements in the Hospital Inpatient Quality Reporting Program. Based on our estimation of 15 minutes to submit the ECE Request Form, the total burden calculation for the submission of 195 ECE Request Forms was 2,925 minutes (or 48.75 hours) across 3,050 IPPS hospitals. Note that non-IPPS hospitals do not need this form because they participate in quality data reporting on a voluntary basis. We were conservative in our estimate (provided in Table 3 above) of 1,138 hours across all IPPS and non-IPPS hospitals, thus this 48.75 hours ECE Request Form burden estimation is accounted for in that figure.

We estimate the information collection burden per hospital associated with completing all other forms used in the data collection process to be $13.77 (0.25 hours x $55.06). For all 4,550 IPPS and non-IPPS hospitals, we estimate a total annual burden of 1,138 hours (0.25 hours x 4,550 hospitals) at a cost of $62,631 (1,138 hours x $55.06).

Beginning with the FY 2025 program year, the burden associated with the Measure Exception Form for NHSN HAI Data Submission was accounted for under OMB control number 0938-1352 (expiration date February 28, 2029) for the HAC Reduction Program. We estimate the form requires 10 minutes (0.167 hours) to submit and based on data from previous years, assume 240

hospitals will complete the form annually. As a result, we estimate the burden associated with this form to be 40 hours annually (0.167 hours x 240 hospitals) at a cost of $2,202 (40 hours x $55.06). After subtracting this burden from the total burden of 1,138 hours at a cost of $62,631 for all forms under OMB control number 0938-1022, we estimate a revised total annual burden of 1,098 hours at a cost of $60,429.

(k) Claims-Based Measure Burden

In the FY 2027 IPPS/LTCH PPS final rule, we adopted the Excess Days in Acute Care After Hospitalization for Diabetes measure beginning with the July 1, 2025 through June 30, 2027 performance period, associated with the FY 2029 payment determination. We also adopted five mortality measures for the July 1, 2024 through June 30, 2026 performance period, associated with the FY 2028 payment determination, through the July 1, 2027 through June 30, 2029 performance period, associated with the FY 2031 payment determination: (1) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization measure; (2) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following HF Hospitalization measure; (3) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure; (4) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following COPD Hospitalization measure; and (5) the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery measure. Lastly, we modified three Excess Days in Acute Care after Hospitalization measures, including AMI, HF, and Pneumonia.

Claims-based measures use information derived through Medicare 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. As a result, the Hospital Inpatient Quality Reporting Program's claims-based measures (see Table 1) do not influence our burden calculations.

(l) Survey Measure Burden

We did not make changes to the information collection requirements for survey measures in the FY 2027 IPPS/LTCH PPS final rule. The information collection requirements associated with HCAHPS Survey measure are currently approved under OMB control number 0938-0981, which expires November 30, 2027.

(m) Burden Estimate Summary

As shown in Tables 8 and 9, in summary, under OMB control number 0938-1022, we estimate a total information collection burden of 1,354,664 at a cost of $73,424,664 for the CY 2027 reporting period/FY 2029 payment determination. We also estimate an annual increase of 12,174 hours and $670,272 for 4,550 IPPS and non-IPPS hospitals associated with our finalized policies and updated burden estimates described above related to this information collection (which also reflects use of updated hourly wage rates as previously discussed), from the CY 2027 reporting period/FY 2029 payment determination through the CY 2030 reporting period/FY 2032 payment determination, compared to our currently approved information collection burden estimates. The tables below summarize the total burden changes for each respective FY payment determination compared to our currently approved information collection burden estimates (the columns in each table for the FY 2032 payment determination reflects the cumulative burden changes).

Table 8. Summary of Annual Burden Hour Estimates for the FY 2028 through FY 2032 Payment Determination Years

	ANNUAL BURDEN HOURS									
Information Collection	**FY2028**	**Difference from Currently Approved**	**FY2029**	**Difference from Currently Approved**	**FY2030**	**Difference from Currently Approved**	**FY2031**	**Difference from Currently Approved**	**FY2032**	**Difference from Currently Approved**
Chart Abstraction										
IPPS	1,220,000	0	1,220,000	0	1,220,000	0	1,220,000	0	1,220,000	0
Non-IPPS	36,200	0	36,200	0	36,200	0	36,200	0	36,200	0
Hybrid Measures										
IPPS	4,067	0	4,067	0	4,067	0	4,067	0	4,067	0
Non-IPPS	2,000	0	2,000	0	2,000	0	2,000	0	2,000	0
Structural Measures										
IPPS	763	0	763	0	763	0	763	0	763	0
Non-IPPS	375	0	375	0	375	0	375	0	375	0
Reporting eCQMs										
IPPS	17,030	0	19,063	0	29,230	6,141	29,230	6,141	31,263	8,174
Non-IPPS	8,375	0	9,375	0	14,375	3,000	14,375	3,000	15,375	4,000
PRO-PM Measures										
IPPS	40,892	0	40,892	0	40,892	0	40,892	0	40,892	0
Non-IPPS	500	0	500	0	500	0	500	0	500	0
Population and sampling for the ongoing measure sets	18,200	0	18,200	0	18,200	0	18,200	0	18,200	0
eCQM Validation	2,133	0	2,133	0	2,133	0	2,133	0	2,133	0
All other forms used in the data collection process	1,098	0	1,098	0	1,098	0	1,098	0	1,098	0
TOTAL*	**1,351,631**	**0**	**1,354,664**	**0**	**1,369,831**	**9,141**	**1,369,831**	**9,141**	**1,372,864**	**12,174**

* Total burden may vary from the sum of individual measure totals due to rounding.

Table 9. Summary of Annual Burden Cost Estimates for the FY 2028 through FY 2032 Payment Determination Years*

	ANNUAL BURDEN COST									
Information Collection	**FY2028**	**Difference from Currently Approved**	**FY2029**	**Difference from Currently Approved**	**FY2030**	**Difference from Currently Approved**	**FY2031**	**Difference from Currently Approved**	**FY2032**	**Difference from Currently Approved**
Chart Abstraction										
IPPS	$67,173,200	$0	$67,173,200	$0	$67,173,200	$0	$67,173,200	$0	$67,173,200	$0
Non-IPPS	$1,993,172	$0	$1,993,172	$0	$1,993,172	$0	$1,993,172	$0	$1,993,172	$0
Hybrid Measures										
IPPS	$223,911	$0	$223,911	$0	$223,911	$0	$223,911	$0	$223,911	$0
Non-IPPS	$110,120	$0	$110,120	$0	$110,120	$0	$110,120	$0	$110,120	$0
Structural Measures										
IPPS	$41,974	$0	$41,974	$0	$41,974	$0	$41,974	$0	$41,974	$0
Non-IPPS	$20,648	$0	$20,648	$0	$20,648	$0	$20,648	$0	$20,648	$0
Reporting eCQMs										
IPPS	$937,644	$0	$1,049,581	$0	$1,609,376	$338,095	$1,609,376	$338,095	$1,721,313	$450,032
Non-IPPS	$461,128	$0	$516,188	$0	$791,488	$165,180	$791,488	$165,180	$846,548	$220,240
PRO-PM Measures										
IPPS**	$1,088,360	$0	$1,088,360	$0	$1,088,360	$0	$1,088,360	$0	$1,088,360	$0
Non-IPPS	$27,530	$0	$27,530	$0	$27,530	$0	$27,530	$0	$27,530	$0
Population and sampling for the ongoing measure sets	$1,002,092	$0	$1,002,092	$0	$1,002,092	$0	$1,002,092	$0	$1,002,092	$0
eCQM Validation	$117,461	$0	$117,461	$0	$117,461	$0	$117,461	$0	$117,461	$0
All other forms used in the data collection process	$60,428	$0	$60,428	$0	$60,428	$0	$60,428	$0	$60,428	$0

TOTAL	**$73,257,667**	**$0**	**$73,424,664**	**$0**	**$74,259,759**	**$503,275**	**$74,259,759**	**$503,275**	**$74,426,756**	**$670,272**

* Cost estimates are based on updated wage rates. Differences from currently approved burden account for updating estimates of currently approved hours to the new wage rates.
** Includes burden associated with surveys completed by patients receiving care at non-IPPS hospitals (see Section B.12.h)

(n) Information Collection Instruments/Instructions

Of the forms described above in Section B.1.C, the following forms will be revised and submitted with this PRA package:

- The Hospital Quality Reporting Data Accuracy and Completeness Acknowledgement form is being resubmitted to update the bullet points to match the groupings used elsewhere.
- The Request Form for Withholding/Footnoting Data for Public Reporting is being resubmitted to (1) add the Rural Emergency Hospital Quality Reporting Program and Hospital OQR Program (2) remove content related to the Social Drivers of Health measures finalized for removal.
- The CMS Quality Reporting Program APU Reconsideration Request Form is being resubmitted to place "name" and "title" on separate lines to address a common mistaken omission we see when receiving data and to update the validation section as eCQMs will now be validated the same way as chart-abstracted measures.
- The CMS Hospital Inpatient Quality Reporting Program Validation Review for Reconsideration Request Form is being resubmitted to update the discharge quarter column to include year.
- The CMS Quality Program Extraordinary Circumstances Exceptions (ECE) Request Form is being resubmitted for updated instructions, revised deadlines, and to reflect the policy to offer deadline extensions as well as exceptions for program requirements.
- Maternal Morbidity Structural Measure Form is being edited to add a sub-question to collect the name of the Statewide and/or National Perinatal Quality Improvement Collaborative Program in which the hospital participates.
- The eCQM Denominator Declaration form is being resubmitted to update the screenshot of the data form, the measures, the measure names, and the order of the measures to align with changes made in the HQR System.

The following information collection forms will continue to be used without any modifications and are not being revised with this PRA package:

- Hospital Inpatient Quality Reporting Notice of Participation
- Population and Sampling Form
- Hospital Quality Reporting Data Validation Educational Review Form
- THA/TKA Patient-Reported Outcome-based Performance Measure Form
- Hospital Value-Based Purchasing Program Appeal Request Form
- Hospital Value-Based Purchasing Program Independent CMS Review Request Form

13. Capital Costs (Maintenance of Capital Costs)

While we assume the majority of hospitals will report data for the Hospital-Level THA/TKA PRO-PM measure via CMS's HQR System, we assume some hospitals may elect to submit measure data via a third-party CMS-approved survey vendor, for which there are associated costs. Under OMB control number 0938-0981 for the HCAHPS Survey measure (expiration date November 30, 2027), an estimate of approximately $4,200 per hospital is used to account for these costs.

14. Cost to Federal Government

The cost to the Federal Government for maintaining program activities is for supporting data system architecture, data storage, maintenance and updating of information technology infrastructure on the HQR system secure portal, providing ongoing technical assistance to hospital and data vendors, calculation of claims-based measures and validation, measure development and maintenance, the provision of hospitals with feedback and preview reports, as well as costs associated with public reporting, for which these costs support implementation of multiple quality programs for efficiency and economy of scale. Additionally, this program requires three CMS staff at a GS-13 Step 5 level with approximate annual salaries of $138,024 plus benefits (30 percent) of $41,407 per staff member to operate for a cost of $538,293.

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 hospitals for claims-based measures.

15. Program or Burden Changes

We previously requested and received approval for total annual burden estimates under this OMB control number for the CY 2027 reporting period/FY 2029 payment determination of 1,354,665 hours at a total cost of approximately $73.8 million as a result of policies finalized in the FY 2026 IPPS/LTCH PPS final rule. Accounting for updated wage rates, the total cost of $73.8 million decreases to $73.4 million. For the CY 2027 reporting period/FY 2029 payment determination, based on the finalized policies in the FY 2027 IPPS/LTCH PPS final rule, we estimate a total burden of 1,354,664 hours and $73,424,664 (a decrease of 1 hour due to rounding from our estimate in the FY 2026 IPPS/LTCH PPS final rule). This burden estimate represents an increase of 3,032 hours and $242,435 from the currently approved burden estimate of 1,351,632 hours and $73,667,099 for the CY 2026 reporting period/FY 2028 payment determination.

The modifications to the reporting and submission requirements for eCQMs to require mandatory reporting of the Malnutrition Care Score eCQM and to require mandatory reporting of Hospital Harm eCQMs after two years of self-selected reporting beginning with the CY 2028 reporting period/FY 2030 payment determination result in an annual burden increase of 12,133 hours and $668,061. We are also adjusting our burden estimates for eCQMs due to an arithmetic rounding error, resulting in an increase of 41 hours and $2,211. The aggregate increase due to these policies and adjustments is 12,174 hours (12,133 + 41) and $670,272 ($668,061 + $2,211) as shown in Tables 8 and 9.

16. Publication/Tabulation Dates

The goal of the data collection is to tabulate and publish hospital-specific data. We will continue to display hospital quality information for public viewing as required by Social Security Act sections 1886(b)(3)(B)(viii)(VII) for the Hospital Inpatient Quality Reporting Program, 1886(o)(10) for the Hospital Value-Based Purchasing Program, 1886(p)(6) for the HAC Reduction Program, 1886(q)(6) for the Hospital Readmissions Reduction Program, and 1886(n)(4)(B) for the Medicare Promoting Interoperability Program. Hospital data from these initiatives are currently used to populate the Compare tool hosted by HHS, available at: https://www.medicare.gov/care-compare/, or its successor website(s). Data are presented on the Compare tool in a format mainly aimed towards consumers, patients, and the general public, providing access to hospital-specific quality measure performance rates along with state and national performance rates. For certain outcome and cost measures, data are presented on the Compare tool in performance categories of Better, No Different, or Worse than the National Rate. More detailed measure data, including the data used for the Compare tool, are also available to the public as downloadable files at https://data.medicare.gov. Hospital quality data on the Compare tool are currently updated on a quarterly basis. One of the goals of the Hospital Inpatient 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 would become available on the *QualityNet* website (https://qualitynet.cms.gov). We will also display the approved expiration date prominently on the *QualityNet* website's Hospital Inpatient 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.