

Supporting Statement - Part A
Submission of Information for the Medicare Promoting Interoperability
Program: FY 2027 IPPS/LTCH PPS Final Rule (OMB# 0938-1278, CMS-10552)

A. Background

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

The Medicare Promoting Interoperability Program is focused on balancing reporting burden for eligible hospitals and CAHs while also implementing changes designed to incentivize the use of CEHRT to support health information exchange, interoperability, quality measurement and maximizing clinical effectiveness and efficiency.

The information collection requirements through the EHR reporting period in CY 2027 are currently approved under OMB control number 0938-1278 (expiration date March 31, 2029). This request covers data collection requirements beginning with the EHR reporting period in CY 2027. The revised information collection request accounts for the removal of the Office of the National Coordinator for Health Information Technology (ONC) Direct Review and optional ONC-Authorized Certification Body (ONC-ACB) Surveillance attestations, adoption of the Unique Device Identifiers for Implantable Medical Devices measure, updates to the Electronic Prior Authorization measure to make the measure optional for the EHR reporting period in CY 2027 and required beginning with the EHR reporting period in CY 2028, and updated data and wage rates impacting previously approved burden calculations.

B. Justification

1. Need and Legal Basis

The American Recovery and Reinvestment Act of 2009 (Recovery Act) ([Pub. L. 111-5](#)) was enacted on February 17, 2009. Title IV of Division B of the Recovery Act amended Titles XVIII and XIX of the Social Security Act by establishing incentive payments to eligible professionals (EPs), eligible hospitals and CAHs, and Medicare Advantage (MA) organizations participating in the Medicare and Medicaid programs that adopt and successfully demonstrate the meaningful use of CEHRT. These Recovery Act provisions, together with Title XIII of Division A of the Recovery Act, may be cited as the HITECH Act.

The HITECH Act created incentive programs for EPs, eligible hospitals and CAHs (under sections 1886(n) and 1814(l) of the Social Security Act), and MA organizations in the Medicare and Medicaid programs (under section 1853(m)(3) of the Social Security Act) that successfully demonstrated the meaningful use of CEHRT, which included reporting on

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

(a) Medicare Promoting Interoperability Program Measures and Attestations

For the EHR reporting period beginning in CY 2027, eligible hospitals and CAHs were required to report data for or attest to the measures and attestations shown in Table 1, as applicable, annually via an online submission form.

Table 1: Previously Approved Medicare Promoting Interoperability Program Measures and Attestations for the EHR Reporting Period in CY 2027 and Subsequent Years

Objective	Attestation/Measure
N/A	ONC Direct Review*
	ONC-ACB Surveillance (optional)*
	Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT
Protect Patient Health Information	Security Risk Analysis
	SAFER Guides
Electronic Prescribing	e-Prescribing
	Query of Prescription Drug Monitoring Program (PDMP)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information*
	AND
	Support Electronic Referral Loops by Receiving and Reconciling Health Information*
	OR
	Health Information Exchange (HIE) Bi-Directional Exchange
	OR

Objective	Attestation/Measure
	Enabling Information Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) measure
	Electronic Prior Authorization measure
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information
Public Health and Clinical Data Exchange	Report the following 6 measures: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Laboratory Reporting • Antimicrobial Use (AU) Surveillance Measure • Antimicrobial Resistance (AR) Surveillance Measure • Unique Device Identifiers for Implantable Medical Devices Measure (UDI)**
	Submit Level of Active Engagement
	Report one of the following measures (BONUS): • Public Health Registry Reporting • Clinical Data Registry Reporting • Public Health Reporting with TEFCA

*These attestations/measures have been finalized for removal in the FY 2027 IPPS/LTCH PPS final rule.

**This measure was finalized as an addition in the FY 2027 IPPS/LTCH PPS final rule

In addition, eligible hospitals and CAHs are required to report data for eCQMs annually. For eCQMs, information is electronically extracted from EHRs and/or health information technology (HIT) systems. Because patient data are already entered into EHRs and HIT systems as part of clinical practice, only the time associated with electronically submitting data to CMS is accounted for in our burden estimates as part of the Hospital Inpatient Quality Reporting Program under OMB control number 0938-1022 (expiration date December 31, 2028). The currently approved eCQMs for the CY 2027 reporting period and subsequent years are shown in Table 2.

Table 2. Previously Approved Medicare Promoting Interoperability Program eCQMs for the CY 2027 Reporting Period and Subsequent Years

Short Name	Measure Name
Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing
PC-02	Cesarean Birth
PC-07	Severe Obstetric Complications

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

*Signifies a required measure beginning with the CY 2028 reporting period.

** These measures have been finalized for removal in the FY 2027 IPPS/LTCH PPS final rule.

(b) Summary of Finalized Medicare Promoting Interoperability Program Changes

In the FY 2027 IPPS/LTCH PPS final rule, we removed two attestations which will impact information collection burden: (1) the ONC Direct Review Attestation beginning with the EHR reporting period in CY 2026, and (2) the optional ONC-ACB Surveillance Attestation beginning with the EHR reporting period in CY 2026. We also adopted the Unique Device Identifiers for Implantable Medical Devices measure beginning with the EHR reporting period in CY 2027. Lastly, we updated the Electronic Prior Authorization measure to make the measure optional for the EHR reporting period in CY 2027 and required beginning with the EHR reporting period in CY 2028.

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 0938-1278. We adopted two new measures beginning with the CY 2028 reporting period: (1) the Advance Care Planning eCQM and (2) the Hospital Harm-Postoperative Venous Thromboembolism (VTE) eCQM. Additionally, we removed five measures: (1) the Support Electronic Referral Loops by Sending Health Information measure beginning with the EHR reporting period in CY 2029; (2) the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure beginning with the EHR reporting period in CY 2029; (3) the VTE Prophylaxis eCQM beginning with the CY 2028 reporting period; (4) the Intensive Care Unit VTE Prophylaxis eCQM beginning with the CY 2028 reporting period; and (5) the Discharged on Antithrombotic Therapy eCQM beginning with the CY 2028 reporting period. We updated the Electronic Prior Authorization measure by modifying the measure description text and modifying the ONC health IT certification criteria eligible hospitals and CAHs must use to attest “Yes” beginning with the EHR reporting period in CY 2027. We also modified the Malnutrition Care Score eCQM to require mandatory reporting beginning with the CY 2028 reporting period. Lastly, we modified the eCQM reporting and submission requirements with regard to Hospital Harm eCQMs to require mandatory reporting after 2 years of self-selected reporting beginning with the CY 2028 reporting period. None of these policies in the FY 2027 IPPS/LTCH PPS final rule will change

information collection burden under OMB control number 0938-1278, as discussed further in section 12.

(c) Medicare Promoting Interoperability Program Forms

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

2. Information Users

The data collected under this information collection request is used by CMS to validate compliance with the requirements for being a successful meaningful user of CEHRT under the Medicare Promoting Interoperability Program. Participants attest or report data as applicable to the required objectives and measures to meet the required threshold for being considered a meaningful user. They must also electronically submit data for eQMs. If it is determined that the participant is not a meaningful user of CEHRT, they would be subject to a downward payment adjustment. The collection of information burden analysis in the FY 2027 IPPS/LTCH PPS final rule focuses on eligible hospitals and CAHs that report on the objectives, measures, attestations, and eQMs under the Medicare Promoting Interoperability Program.

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

Certain information is available to Medicare beneficiaries, as well as to the general public, by providing hospital information on the *Compare* tool hosted by HHS, currently available at: <https://www.medicare.gov/care-compare>, and the Provider Data Catalog, currently available at: <https://www.data.cms.gov>, or their successor websites, which helps the public make informed decisions about their care. CMS periodically conducts focus groups or market testing to get feedback on ways to make the website more user-friendly. Feedback from these focus groups has helped CMS understand how beneficiaries and consumers use the *Compare* tool hosted by HHS or its successor website(s).

Under section 1890A(a)(6) of the Social Security Act, CMS is required to evaluate the impact and efficiency of CMS measures in quality reporting programs and to post the report every three years. Following the compilation of eCQM data from the Medicare Promoting Interoperability Program and other CMS programs, CMS's findings were formally written into the latest triennial National Impact Assessment Report, which was released in CY 2024.¹

3. Use of Information Technology

To assist eligible hospitals and CAHs in participating in standardized data collection initiatives across the industry, CMS continues to improve data collection tools with the dual goals of making data submission easier (e.g., the automated collection of electronic patient data in EHRs for eQMs), and to increase the utility of the data provided by participants. CMS also provides a secure data warehouse via CMS's Hospital Quality Reporting (HQR) system for storage and transmittal of data. Participants have the option of using vendors to transmit data.

Attestation and data reporting are completed on an annual basis via an online submission form and submission of digital files.

4. Duplication of Efforts

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

5. Small Businesses

We define a "small hospital" as one with 1-99 inpatient beds. Approximately 904 eligible hospitals that participated in the Medicare Promoting Interoperability Program for the EHR reporting period in CY 2024 meet the definition of "small". In addition, as defined under 42 CFR Part 485 subpart F, a CAH may have no more than 25 inpatient beds and therefore, we assume all 1,400 CAHs would qualify as small hospitals. As a result, we estimate a total of 2,304 small hospitals (904 eligible hospitals + 1,400 CAHs) will submit data for the Medicare Promoting Interoperability Program for the EHR reporting period in CY 2027. CMS has engaged a national support contractor to provide technical assistance with program requirements and to provide education to support program participants. In addition, the Health Services & Resources Administration's Medicare Rural Hospital Flexibility Program (Flex) and Medicare Beneficiary Quality Improvement Project, as well as CMS's Quality Improvement Organizations, provide technical assistance to small hospitals to reduce burden and improve healthcare quality. We also provide a help-desk hotline for troubleshooting purposes and 24/7 free information available on the

¹ The latest 2024 Impact Assessment Report, as well as earlier reports from 2012, 2015, 2018, and 2021 may be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/National-Impact-Assessment-of-the-Centers-for-Medicare-and-Medicaid-Services-CMS-Quality-Measures-Reports>.

QualityNet website through a Questions and Answers function.

6. Less Frequent Collection

CMS has designed the collection of information under the Medicare Promoting Interoperability Program to be the minimum necessary for eligible hospitals and CAHs to demonstrate the meaningful use of CEHRT. To implement the meaningful use provisions of the HITECH Act under the Medicare Promoting Interoperability Program, eligible hospitals and CAHs are required to report all Medicare Promoting Interoperability Program data annually. Less frequent information collection would impede efforts to establish compliance with the HITECH Act.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice for the FY 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).

9. Payment/Gift to Respondent

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

10. Confidentiality

We pledge privacy to the extent provided by law. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted. All information collected under the Medicare Promoting Interoperability Program will be maintained in strict accordance with statutes and regulations governing confidentiality requirements for CMS data, including the Privacy Act of 1974 (5 U.S.C. 552a), the Health Insurance Portability and Accountability Act (HIPAA), and the Quality Improvement Organizations confidentiality requirements, which can be found at 42 C.F.R. Part 480. In addition, the tools used for transmission of data are considered confidential forms of communication, and there are safeguards in place in accordance with HIPAA Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. Only hospital-specific data will be made publicly available as mandated by statute. The data collected will be for CMS internal use only and will not be published, except as finalized for public display under section 1886(n)(4)(B) of the Social Security Act, which requires the Secretary to post on the CMS website, in an easily understandable format, a list of the names of the eligible hospitals and CAHs that are meaningful EHR users, and other relevant data as determined appropriate by the

Secretary.

Data related to the Medicare Promoting Interoperability Program is housed in the HQR application group. CMS'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.

11. Sensitive Questions

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

12. Burden Estimate (Total Hours and Wages)

(a) Background

In section B.1.b., we describe all the finalized policies for the Medicare Promoting Interoperability Program for eligible hospitals and CAHs in the FY 2027 IPPS/LTCH PPS final rule.

Regarding policies in the FY 2027 IPPS/LTCH PPS final rule that affect information collection burden under OMB control number 0938-1278, we finalized the removal of two attestations: (1) the ONC Direct Review Attestation beginning with the EHR reporting period in CY 2026; (2) the optional ONC-ACB Surveillance Attestation beginning with the EHR reporting period in CY 2026. We also finalized adoption of the Unique Device Identifiers for Implantable Medical Devices measure beginning with the EHR reporting period in CY 2027. Lastly, we finalized updates to the Electronic Prior Authorization measure to make the measure optional for the EHR reporting period in CY 2027 and required beginning with the EHR reporting period in CY 2028.

(b) Burden for the EHR Reporting Period in FY 2027

Based on data from the EHR reporting period in CY 2025, we are maintaining our estimate of approximately 3,150 eligible hospitals and 1,400 CAHs that will report data to the Medicare Promoting Interoperability Program beginning with the EHR reporting period in CY 2027, for a total number of 4,550 respondents.

OMB has currently approved a burden of 30,151 hours at a cost of \$1,669,707 under OMB control number 0938-1278, accounting for information collection burden experienced by approximately 3,150 eligible hospitals and 1,400 CAHs for the EHR reporting period in CY 2026. As shown in Table 3, we estimate a total burden of 30,150 hours with an updated cost of \$1,660,059 for the EHR reporting period in CY 2026; this reflects a decrease of 1 hour due to an error in arithmetic rounding and a decrease of \$9,648, accounting for our revised burden hour estimate and updated wage rates. As previously stated, our burden estimates exclude burden associated with eCQM reporting for eligible hospitals and CAHs which is accounted for in our burden estimates as part of the Hospital Inpatient Quality Reporting Program under OMB control number 0938-1022.

Table 3: Currently Approved Burden Estimates for the Medicare Promoting Interoperability Program for the EHR Reporting Period in CY 2026

<i>Objective/Measure</i>	<i>Estimated Time per Eligible Hospital/CAH (minutes)</i>	<i>Frequency of reporting per year</i>	<i>Number of eligible hospitals/CAHs</i>	<i>Number records per hospital per quarter</i>	<i>Total Burden Hours for EHR Reporting Period in CY 2026</i>
Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT attestation	1	1	4,550	1	76
ONC Direct Review attestation	1	1	4,550	1	76
PROTECT PATIENT HEALTH INFORMATION					
Security Risk Analysis Measure	360	1	4,550	1	27,300
SAFER Guides Measure	1	1	4,550	1	76
ELECTRONIC PRESCRIBING					
e-Prescribing Measure	10	1	4,550	1	758
Query of PDMP Measure	0.5	1	4,550	1	38
HEALTH INFORMATION EXCHANGE					
Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures OR HIE Bi-Directional Exchange Measure OR Enabling Information Exchange Under the TEFCA Measure	10	1	4,550	1	758
Electronic Prior Authorization Measure*	0	1	4,550	1	0
PROVIDER TO PATIENT EXCHANGE					
Provide Patients Electronic Access to Their Health Information Measure	10	1	4,550	1	758
PUBLIC HEALTH AND CLINICAL DATA EXCHANGE					
Syndromic Surveillance Reporting Measure	0.5	1	4,550	1	38
Immunization Registry Reporting Measure	0.5	1	4,550	1	38
Electronic Case Reporting Measure	0.5	1	4,550	1	38

Electronic Laboratory Reporting Measure	0.5	1	4,550	1	38
AU Surveillance Measure	0.5	1	4,550	1	38
AR Surveillance Measure	0.5	1	4,550	1	38
Submit Level of Active Engagement	0.5	1	4,550	1	38
Bonus Measures: Public Health Registry Reporting Measure OR Clinical Data Registry Reporting Measure OR Public Health Reporting Using TEFCA Measure	0.5	1	4,550	1	38
Hardship Exception applications	1	1	400	1	7
Total Burden Hours					30,150
Total Burden @ Medical Records Specialist labor rate (\$55.06)					\$1,660,059

* The Electronic Prior Authorization measure was previously finalized to be required beginning with the EHR Reporting Period in CY 2027. At that time, the burden per eligible hospital and CAH will be 0.5 minutes.

(c) Updated Hourly Wage Rate

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, we use the mean hourly wage for medical records specialists for the industry, “general medical and surgical hospitals,” which is \$27.53.² We believe the industry of “general medical and surgical hospitals” is more specific to 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 \times 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 Medicare Promoting Interoperability Program.

(d) Attestations not associated with an Objective

As currently approved, eligible hospitals and CAHs are required to report on the Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT attestation as required by section 1886(n)(3)(A)(ii) of the Social Security Act and the ONC Direct Review attestation to be considered a meaningful EHR user. As attestations, eligible

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

hospitals and CAHs are required to report a “yes” or “no” response for each attestation. Eligible hospitals and CAHs may also elect to report a “yes” or “no” for the optional ONC-ACB Surveillance attestation. For burden purposes, we assume all eligible hospitals and CAHs will elect to report this optional attestation.

We note that although the optional ONC-ACB Surveillance attestation was finalized in the CY 2017 Quality Payment Program final rule with comment period (81 FR 77019 through 77028), the associated information collection burden of 1 minute (0.0167 hours) per eligible hospital and CAH has not previously been accounted for under OMB control number 0938-1278. In the FY 2027 IPPS/LTCH PPS final rule, we removed the optional ONC-ACB Surveillance attestation beginning with the EHR reporting period in CY 2026. As a result, we estimate no net impact to information collection burden under OMB control number 0938-1278 associated with this policy.

Also in the FY 2027 IPPS/LTCH PPS final rule, we removed the ONC Direct Review attestation beginning with the EHR reporting period in CY 2026. As a result, we estimate a decrease of 76 hours ($0.0167 \text{ hours} \times 4,550 \text{ eligible hospitals and CAHs}$) annually at a cost of \$4,185 ($76 \text{ hours} \times \55.06) associated with this policy.

We continue to estimate an information collection burden for each eligible hospital and CAH of 1 minute to report the Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT attestation. We therefore estimate a total burden of 76 hours ($0.0167 \text{ hours} \times 4,550 \text{ eligible hospitals and CAHs}$) annually at a cost of \$4,185 ($76 \text{ hours} \times \55.06).

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

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

We continue to estimate eligible hospitals and CAHs require approximately 6 hours annually to conduct or review a security risk analysis and conduct security risk management activities in accordance with the requirements under 45 CFR 164.308(a)(1)(ii)(A) and (B), including addressing the security of data created or maintained by CEHRT (to include encryption). We also continue to estimate eligible hospitals and CAHs require approximately 1 minute to attest to the SAFER Guides reporting measure annually.

We continue to estimate a total burden for this Objective for each hospital of 361 minutes (6.0167 hours) to successfully meet the requirements of this Objective. We estimate a total burden for this Objective for all eligible hospitals and CAHs of 27,376 hours (6.0167 hours × 4,550 eligible hospitals and CAHs) annually at a cost of \$1,507,323 (27,376 hours x \$55.06).

(f) Electronic Prescribing Objective Reporting and Submission Burden

As shown in Table 3, for the Electronic Prescribing Objective, eligible hospitals and CAHs are required to report both the Electronic Prescribing and Query of PDMP measures. We continue to estimate that eligible hospitals and CAHs require 10 minutes to report the Electronic Prescribing measure and 0.5 minutes to report the Query of PDMP measure for a total of 10.5 minutes (0.175 hours) to report both measures. We estimate a total burden for this Objective of 796 hours across all eligible hospitals and CAHs (0.175 hours × 4,550 eligible hospitals and CAHs) annually at a cost of \$43,828 (796 hours x \$55.06).

(g) Health Information Exchange Objective Reporting and Submission Burden

As shown in Table 3, for the Health Information Exchange Objective, eligible hospitals and CAHs have been required to report one of three alternatives: (1) the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures; (2) the HIE Bi-Directional Exchange measure; or (3) the Enabling Exchange Under the TEFCA measure. In the FY 2027 IPPS/LTCH PPS final rule, we removed the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures beginning with the EHR reporting period in CY 2029. Because eligible hospitals and CAHs will still be required to report either the HIE Bi-Directional Exchange or Enabling Exchange Under the TEFCA measure, we are not making any changes to information collection burden associated with this policy. We continue to estimate eligible hospitals and CAHs will require 10 minutes (0.167 hours) to report on one of the two alternatives.

In the Advancing Interoperability and Improving Prior Authorization Processes for MA Organizations and Medicaid Managed Care Plans, State Medicaid Agencies, State CHIP Agencies, CHIP Managed Care Entities, and Issuers of QHPs in the Federally-Facilitated Exchanges Final Rule published on February 8, 2024 (89 FR 8758), we finalized the Electronic Prior Authorization measure beginning with the EHR reporting period in CY 2027. As an attestation measure, eligible hospitals and CAHs are required to report a “yes” or “no” response. In the FY 2027 IPPS/LTCH PPS final rule, we finalized that eligible hospitals and CAHs must use one or more of the Health IT modules certified to the criteria at 45 CFR 170.315(g)(31), (32), and (33) to report on the Electronic Prior Authorization measure beginning with the EHR reporting period in CY 2027. We also modified the Electronic Prior Authorization measure description such that for at least one medical item or service (excluding drugs) requiring prior authorization ordered during a hospital encounter that occurs within the EHR reporting period, the prior authorization is requested electronically through a Prior Authorization API using CEHRT. Eligible

hospitals and CAHs may also claim an applicable exclusion. Because we are only updating the criteria which eligible hospitals and CAHs will have to meet to attest “Yes,” we are not making any changes to information collection burden associated with these policies. Lastly, we finalized making Electronic Prior Authorization measure optional for the EHR reporting period in CY 2027 and required beginning with the EHR reporting period in CY 2028. We continue to estimate that eligible hospitals and CAHs require 0.5 minutes (0.0083 hours) to report this measure. Because we are unable to estimate the number of eligible hospitals and CAHs which may elect not to attest to this measure for the EHR reporting period in CY 2027 as a result of this policy, for burden purposes, we are not making any changes to the currently approved burden estimates.

In aggregate, for the EHR reporting period in CY 2027 and subsequent years, we estimate a total burden for this Objective across all eligible hospitals and CAHs of 796 hours (0.175 hours x 4,550 hospitals) at a cost of \$43,828 (796 hours x \$55.06).

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

As shown in Table 3, we continue to estimate eligible hospitals and CAHs require 10 minutes (0.167 hours) to report on the Provide Patients Electronic Access to Their Health Information measure. Therefore, we estimate a total information collection burden for this Objective of 758 hours (0.167 hours x 4,550 hospitals) at a cost of \$41,735 (758 hours x \$55.06).

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

As shown in Table 3, for the Public Health and Clinical Data Exchange Objective, eligible hospitals and CAHs must attest to six measures: (1) the Syndromic Surveillance Reporting Measure, (2) the Immunization Registry Reporting Measure, (3) the Electronic Case Reporting Measure, (4) the Electronic Laboratory Reporting Measure, (5) the AU Surveillance Measure; and (6) the AR Surveillance Measure. In addition, eligible hospitals and CAHs may attest to one of the optional bonus Public Health Registry Reporting or Clinical Data Registry Reporting measures. We note that under the AU and AR Surveillance Measures, while eligible hospitals and CAHs are required to attest to active engagement with CDC’s National Healthcare Safety Network (NHSN) to submit AU and AR data, and receive a report from NHSN indicating their successful submission of AU and AR data for the EHR reporting period, the burden associated with the actual submission of AU and AR data to NHSN is accounted for under OMB control number 0920-0666 (expiration date March 31, 2029).

Additionally, our currently approved burden estimates assume that eligible hospitals and CAHs are required to attest to their level of active engagement (either Pre-production and Validation or Validated Data Production) once for all measures under this Objective. Upon review of the current attestation process for eligible hospitals and CAHs, we are revising our assumption to reflect that eligible hospitals and CAHs are required to attest to their level of active engagement for each of the six required measures and one bonus measure, for a total of seven attestations, under this Objective.

In the FY 2027 IPPS/LTCH PPS final rule, we adopted the Unique Device Identifiers for Implantable Medical Devices measure beginning with the EHR reporting period in CY 2027. For this attestation-based measure, eligible hospitals and CAHs will be required to report a “Yes” response, a “No” response, or claim an applicable exclusion for which they are eligible. Similar to other attestations under this Objective, we assume eligible hospitals and CAHs require 30 seconds (0.5 minutes) to attest to this measure. Eligible hospitals and CAHs are already required to record and maintain patient-linked information for certain implantable devices under 21 CFR Part 821 (Medical Device Tracking), including § 821.30. Although the regulation does not specify the format or location of such documentation, hospitals must maintain sufficient records to support device tracking. Accordingly, specifying that Unique Device Identifier information be entered into the EHR represents a clarification of documentation expectations rather than a new information collection. Therefore, we assume no additional information collection burden under OMB Control Number 0938-1270.

We estimate the burden associated with each of the 15 attestations required under this Objective to be 0.5 minutes/measure for a total of 7.5 minutes (0.125 hours) in aggregate (0.5 minutes x 15 attestations). Across all eligible hospitals and CAHs, we estimate a total annual burden of 569 hours (0.125 hours x 4,550 hospitals) at a cost of \$31,329 (569 hours x \$55.06).

(j) eCQM Measure Reporting and Submission Requirements

The burden associated with the reporting of eCQM measures for eligible hospitals and CAHs are accounted for under OMB control number 0938-1022. In the FY 2027 IPPS/LTCH PPS final rule, we adopted two new eCQMs that will be available for eligible hospitals and CAHs to self-select to report beginning with the CY 2028 reporting period: (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, and to require mandatory reporting of Hospital Harm eCQMs after two years of self-selected reporting beginning with the CY 2028 reporting period, including the newly adopted Hospital Harm-Postoperative VTE eCQM. In the previously approved eCQM measure set, there are two Hospital Harm eCQMs from which an eligible hospital or CAH could 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, because they were adopted in the FY 2025 IPPS/LTCH PPS final rule for self-selection eCQMs beginning with the CY 2026 reporting period (89 FR 69621 and 69622). Lastly, we removed three eCQMs available for eligible hospitals and CAHs to self-select to report beginning with the CY 2028 reporting period: (1) the VTE Prophylaxis eCQM; (2) the Intensive Care Unit VTE eCQM; and (3) Discharged on Antithrombotic Therapy eCQM.

For the CY 2027 reporting period, CAHs are required to submit data for nine eCQMs: three self-selected eCQMs, and the Safe Use of Opioids, Severe Obstetric Complications, Cesarean Birth Rate, Hospital Harm – Severe Hypoglycemia, Hospital Harm – Severe

Hyperglycemia, and the Hospital Harm – Opioid-Related Adverse Events eQMs. For the CY 2028 and CY 2029 reporting periods, CAHs will be required to submit data for these nine eQMs 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 eQMs. For the CY 2030 reporting period and subsequent years, CAHs will be required to submit data for these 14 eQMs as well as the Hospital Harm – Postoperative VTE eQM.

(k) Hardship Exception

As discussed in section B.1.(c), eligible hospitals and CAHs may apply electronically for a Hardship Exception and avoid a downward payment adjustment in circumstances out of the hospital's control that make it difficult to meet program requirements. Based on the number of Hardship Exception applications received in prior EHR reporting periods, we estimate approximately 400 eligible hospitals and CAHs will apply annually and estimate the application requires approximately 1 minute (0.0167 hours) to complete. Therefore, we estimate an annual information collection burden of 7 hours (0.0167 hours x 400 applications) at a cost of \$385 (7 hours x \$55.06).

(l) Burden Estimate Summary

As shown in Table 4, in summary, under OMB control number 0938-1278, we estimate an increase of 190 hours and \$10,462 in information collection burden associated with our revised assumptions and finalized policies (which also reflects use of updated hourly wage rates as previously discussed), for the EHR reporting period in CY 2027 and subsequent years, compared to our currently approved information collection burden estimates. The table below summarizes the total burden changes for each respective EHR reporting period compared to our currently approved information collection burden estimates.

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

Objective	EHR Reporting Period in CY 2027 and Subsequent Years	Difference From Currently Approved
Attestations not associated with an Objective	76	-76
Protecting Patient Health Information	27,376	0
Electronic Prescribing	796	0
Health Information Exchange	796	0
Provider to Patient Exchange	758	0
Public Health and Clinical Data Exchange	569	+266
Hardship Exception	7	0
Total Burden Hour Estimate*	30,378	+190
Total Burden Cost Estimate*	\$1,672,613	+\$10,462

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

These burden estimates exclude burden associated with the reporting of eCQMs for eligible hospitals and CAHs under OMB control number 0938-1022, as Medicare hospitals report the data to CMS once per year for credit under both the Hospital Inpatient Quality Reporting Program and the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

(m) Information Collection Instruments/Instructions

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

13. Capital Costs (Maintenance of Capital Costs)

To attest to the AU Surveillance and AR Surveillance measures successfully, an eligible hospital or CAH must be in active engagement with CDC's NHSN to submit AU and AR data and receive a report from NHSN indicating their successful submission of AU and AR data for the EHR reporting period. We previously discussed in our currently approved PRA application that participation in NHSN's surveillance requires the use of an AUR reporting solution. We estimate the annual cost for commercial software and equipment for use by hospital personnel to range between \$59,100 and \$146,500 annually, with a median of \$70,900.³ We believe these associated costs are outweighed by the more than \$4.6 billion in health care costs spent annually treating antibiotic resistance threats.⁴

14. Cost to the Federal Government

The cost to the Federal Government for maintaining multiple hospital quality reporting program activities is for supporting data system architecture, data storage, maintenance and updating of information technology infrastructure on the HQR system secure portal, providing ongoing technical assistance to hospital and data vendors, measure development and maintenance, the provision of hospitals with feedback and preview reports, as well as costs associated with public reporting. These costs are estimated at \$10,050,000 annually for the validation and quality reporting contracts. Additionally, this program takes three CMS staff at a GS-13 Step 5 level with approximate annual salaries of \$138,024 plus benefits (30%) of \$41,407 per staff member to operate for an additional cost of \$538,293. The total annual cost to the Federal Government is \$10,588,293.

15. Program or Burden Changes

We previously requested and received approval for total annual burden estimates under this OMB control number for the EHR reporting period in CY 2027 of 30,188 hours at a total cost of \$1,671,811 as a result of policies finalized in the FY 2026 IPPS/LTCH PPS final rule. Accounting for updated wage rates, the total cost of \$1,671,811 decreases to

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5051263/>

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

\$1,662,151 (a decrease of \$9,660 from our currently approved estimate). For the EHR reporting period in CY 2027, based on the finalized policies in the FY 2027 IPPS/LTCH PPS final rule and revised assumptions, we estimate a total burden of 30,378 hours and \$1,672,613 (an increase of 190 hours and \$10,462 from our estimate in the FY 2026 IPPS/LTCH PPS final rule). This burden estimate represents an increase of 227 hours and \$2,906 from the currently approved burden estimate of 30,151 hours and \$1,669,707 for the EHR reporting period in CY 2026.

The removal of the ONC Direct Review attestation results in a decrease of 76 hours and \$4,185. The adoption of the Unique Device Identifiers for Implantable Medical Devices measure results in an increase of 38 hours and \$2,092. The revised assumptions for level of active engagement attestations results in an increase of 228 hours and \$12,555. In aggregate, these policies and revisions result in an increase of 190 hours (-76 + 38 + 228) and \$10,462 (-\$4,185 + \$2,092 + \$12,555).

16. Publication/Tabulation Dates

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

17. Expiration Date

Except for the online form used for submitting attestations and Hardship Exception application which will display the approved expiration date, there are no additional forms associated with the Medicare Promoting Interoperability Program. We will also display the approved expiration date prominently on the Medicare Promoting Interoperability Program pages on [HQR](#) used to document our measure specifications and reporting guidance.

18. Certification Statement

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

B. Collection of Information Employing Statistical Methods

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