

Supporting Statement – Part A
Quality Measures and Procedures for the Hospital Inpatient Quality Reporting Program
for the FY 2023 IPPS Annual Payment Updates (OMB Control No. 0938-1022)
FY 2021 IPPS/LTCH PPS Proposed Rule (RIN 0938-AT73, CMS-1735-P)

A. Background

The Centers for Medicare & Medicaid Services (CMS) seeks to empower consumers to make more informed decisions about their health care and to promote higher quality of care through its quality reporting programs. To begin participation in the Hospital Inpatient Quality Reporting (IQR) Program, all hospitals paid under the Inpatient Prospective Payment System (IPPS) must complete a Hospital IQR Notice of Participation. The Notice of Participation explains the participation and reporting requirements for the program. The form explains that in order to receive the full market basket update (or annual payment update (APU)), the hospitals are agreeing to submit data on selected measures and allowing CMS to publish their data for public viewing according to section 1886(b)(3)(B)(viii) of the Social Security Act. Other hospitals not paid under IPPS, such as critical access hospitals, may also wish to voluntarily submit data and have their data published for public viewing. In order to accommodate these hospitals, a separate section of the participation form, referred to as the Optional Public Reporting Notice of Participation, is available for these hospitals to give CMS permission to collect and publish data that are voluntarily submitted by a hospital. These hospitals may choose to suppress a measure or measures prior to their posting on the CMS *Hospital Compare* website or its successor website(s). In order to reduce burden, a hospital that indicated its intent to participate will be considered an active Hospital IQR Program participant until the hospital submits a withdrawal to CMS. Hospitals that no longer wish to participate in the Hospital IQR Program or those that no longer wish to submit data for publishing on *Hospital Compare* or its successor website(s) can notify CMS of their decision using the same form discussed above.

Annually, hospitals participating in hospital quality reporting use the Hospital Quality Reporting Data Accuracy and Completeness Acknowledgement (DACA) form after the end of each reporting year. This requirement was added based on a U.S. Government Accountability Office report from 2006 that recommended that CMS require hospitals to “formally attest to the completeness of the quality data that they submit.” This form, completed annually, is simply an acknowledgement that the data a hospital has submitted are complete and accurate.

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. However, the data will be released on *Hospital Compare* or its successor website(s) for subsequent releases unless the hospital submits a new Request Form for Withholding/Footnoting Data from Public Reporting indicating the measure(s) the hospital would like to withhold from public reporting for the period.

Hospitals that do not treat specified conditions or that do not have treatment locations defined for certain of the National Healthcare Safety Network’s healthcare-associated infection (HAI) measures (CLABSI, CAUTI, and Surgical Site Infection) have the option to either complete the

enrollment process with National Healthcare Safety Network and indicate that they do not have patients who meet the measure requirements, or submit a CMS IPPS Quality Reporting Programs Measure Exception Form for PC and HAI Data Submission. Hospitals that do not have an Obstetrics Department and do not deliver babies may also use this form for the PC-01: Elective Delivery measure. This Measure Exception Form will reduce the burden of completing the entire National Healthcare Safety Network enrollment process or entering zero denominator information for inapplicable measures for the hospitals that meet the exception requirements.

Currently, CMS selects up to 600 subsection (d) hospitals participating in the Hospital IQR Program on an annual basis for validation of chart-abstracted measures (77 FR 53551 through 53553). In addition to validation of chart-abstracted measure data, up to 200 hospitals are also randomly selected for electronic Clinical Quality Measure (eCQM) validation under the Hospital IQR Program (81 FR 57174 through 57178). We also are proposing to make several changes to streamline the validation process. We are proposing to: (1) align the hospital selection, submission quarters, and scoring processes in the validation of clinical process of care and eCQM measures data beginning with the FY 2024 payment determination, (2) formalize the process for conducting educational reviews for eCQM validation in alignment with current processes for providing feedback for chart-abstracted validation results; and (3) use only digital submissions (i.e., PDFs) via secure file transfer for Medical Records Requests from the Clinical Data Abstraction Center (CDAC) for the validation of clinical process of care measures.

When CMS determines that a hospital did not meet one or more of the Hospital IQR Program requirement(s), 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 IQR Program Annual Payment Update Notification Letter it received. For reconsideration requests related specifically to the validation requirements, hospitals must use the CMS Hospital IQR Program Validation Review for Reconsideration Request Form.

Hospitals may use the educational review process to correct disputed chart-abstracted measure validation results for the first three quarters of validation. In this year's rule we are proposing to extend that process to eCQMs as well. 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 IQR Program Validation Review for Reconsideration Request Form.

CMS offers a process for hospitals to request exceptions 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. The CMS Quality Program Extraordinary Circumstances Exceptions Request Form indicates that for non-eCQM circumstances, the request must be submitted within 90 calendar days of an extraordinary circumstance event for all programs. In addition, the form indicates that for eCQM reporting circumstances under the Hospital IQR Program, the request must be submitted by April 1st following the end of a reporting period calendar year.

As noted above, we may only select measures for the Hospital Value-Based Purchasing (VBP) Program from the measures (other than measures of readmissions) specified under the Hospital IQR 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 VBP Program. Hospitals may review and request recalculation of their hospital's performance scores on each condition, domain, and TPS using the Hospital VBP Program Review and Corrections Request Form within 30 calendar days of the posting date of the Value-Based Percentage Payment Summary Report. Hospitals may submit an appeal using the VBP Program Appeal Request Form within 30 calendar days of the date of receiving an adverse determination from CMS on their review and corrections request. Hospitals may submit a Hospital VBP Program Independent CMS Review Request Form within 30 days after they receive an adverse determination from CMS on their appeal.

1. **Hospital IQR Program Quality Measures**

The FY 2023 APU determination will be based on Hospital IQR Program data reported and supporting forms submitted by hospitals on chart-abstracted measures, patient surveys, and eQMs for calendar year (CY) 2021 discharges. In an effort to reduce burden, a variety of different data collection mechanisms are employed, with every consideration taken to employ data and data collection systems already in place.

For the FY 2021 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) PPS proposed rule, existing measures, including population and sampling for ongoing measure sets, reviewing reports for claims-based measure sets, and all other forms used in the data collection process remain unchanged. Proposed changes to certain reporting and submission requirements for eQMs and proposed changes to streamline the data validation process are discussed below.

a. Proposals in the FY 2021 IPPS/LTCH PPS Proposed Rule Which May Affect the Burden for the Hospital IQR Program

In the FY 2021 IPPS/LTCH PPS proposed rule, we are not proposing to add or remove any measures from the program.

For eQCM reporting, we are proposing to progressively increase the numbers of quarters of eQCM data reported, from one self-selected quarter of data to four quarters of data over a three year period, by requiring hospitals to report two quarters of data for the CY 2021 reporting period/FY 2023 payment determination, three quarters of data for the CY 2022 reporting period/FY 2024 payment determination, and four quarters of data beginning with the CY 2023 reporting period/FY 2025 payment determination and for subsequent years.

We are also proposing to streamline validation processes under the Hospital IQR Program by aligning validation processes for chart-abstracted measures and eQMs. We would do this by aligning hospital selection, including: (i) reducing the pool of hospitals randomly selected for chart-abstracted measure validation; and (ii) integrating and applying targeting criteria for eQCM validation.

We expect these proposals identified above will increase our collection of information burden estimates. Details on these policies as well as the expected burden changes are discussed further below.

b. Proposals in the FY 2021 IPPS/LTCH PPS Proposed Rule Which Should Not Affect the Burden for the Hospital IQR Program

In the FY 2021 IPPS/LTCH PPS proposed rule, there are a few proposals which we do not expect will affect our information collection burden estimates, including: (1) initiating public display of eCQM data beginning with data reported by hospitals for the CY 2021 reporting period and for subsequent years; (2) requiring the use of electronic file submissions via a CMS-approved secure file transmission process and no longer allowing the submission of paper copies of medical records or copies on digital portable media such as CD, DVD, or flash drive; (3) aligning the validation processes for chart-abstracted measures and eCQMs by: (a) aligning data submission quarters, and (b) aligning scoring processes by providing one combined validation score for the validation of chart-abstracted measures and eCQMs with the eCQM portion of the combined score weighted at zero; (4) formalizing the process for conducting educational reviews for eCQM validation in alignment with current processes for providing feedback for chart-abstracted validation results; and (5) proposing to add EHR Submitter ID as a new key element for QRDA I file identification beginning with the CY 2021 reporting period/FY 2023 payment determination.

B. Justification

1. Need and Legal Basis

The Hospital IQR 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. It builds on a voluntary Inpatient Quality Reporting Program, which remains in effect. 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) 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’ 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 VBP Program from the measures (other than measures of readmissions) specified under the Hospital IQR Program. Consistent with this legislation, CMS established a Hospital VBP 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 VBP Program from the measures specified under the Hospital IQR Program.

2. Information Users

The information from the Hospital IQR Program will be made available to hospitals for their use in internal quality improvement initiatives. CMS provides confidential feedback reports that hospitals may use to assess their performance and operationalize quality improvement activities throughout the quality reporting period. These reports include the data that CMS has collected from the hospital and the hospital's claims, and some also include information about how the hospital's data look relative to the performance of other hospitals. For example, the Facility, State and National (FSN) Report allows hospitals to compare their performance related to a specific measure during a specific timeframe, to the average performance of other hospitals at the state and national levels.

CMS will use the information collected from hospital quality reporting to set payment adjustments for value-based purchasing. For example, the Hospital VBP 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 VBP payment determinations while there is still time to target improvement activities related to specific measures so that their performance and scores can be maximized.

Hospital measure information is also used by CMS to direct its contractors to focus on particular areas of improvement and to develop quality improvement initiatives. Medicare beneficiaries experience a high rate of preventable readmissions, which are burdensome to patients and families, as well as costly. Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs), under contract with CMS, use readmissions data from CMS to assist communities to reduce avoidable readmissions. For example, the QIN-QIO program helps communities with high readmission rates form local coalitions, identify the factors driving avoidable hospital readmissions in their area, and find ways to better coordinate care and to encourage patients to manage their health more actively.

Most importantly, this information is available to beneficiaries, as well as to the public, to provide hospital information to assist them in making decisions in choosing their health care providers. CMS sometimes conducts focus groups or market testing prior to publicly reporting hospital quality data on the *Hospital Compare* website or its successor website(s) in order to get feedback on ways to make the website more user-friendly. Feedback from these focus groups have helped CMS understand how beneficiaries and consumers use *Hospital Compare*. Under emergency circumstances, consumers choose hospitals based on proximity, reputation, prior experience, or their doctor's recommendation. For childbirth or elective hospital admissions, when patients and their family members may have the time and motivation to consider options and engage in informed decision making, they have expressed interest in information such as the provider's track record in treating their condition, safety and infection rates, and a hospital's recognized areas of expertise, as well as to take into consideration their doctor's recommendation.

3. Use of Information Technology

To assist hospitals in standardizing data collection initiatives across the industry, CMS continues to improve data collection tools in order to make data submission easier for hospitals (e.g., the automated collection of electronic patient data in EHRs for eCQMs and hybrid measures, the collection of data from paper or electronic medical records for chart-abstracted measures, or the collection of data from federal registries like the National Healthcare Safety Network), as well as to increase the utility of the data provided by the hospitals. In addition, we are advancing our ongoing commitment to promote efficiency through health information technology and increased EHR-based reporting, as demonstrated by the proposals in the FY 2021 IPPS/LTCH PPS proposed rule related to eCQM reporting and submission requirements and updates to the processes for validation of Hospital IQR Program measure data, details of which are further discussed below.

For the claims-based measures, this section is not applicable, because claims-based measures can be 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 for these measures.

4. Duplication of Similar Information

The information to be collected is not duplicative of similar information collected by CMS. We prioritize efforts to reduce reporting burden for the collection of quality of care information by utilizing electronic data that hospitals already report to The Joint Commission for accreditation, as well as aligning eCQMs and related reporting requirements with the Promoting Interoperability Program.

5. Small Business

Information collection requirements were 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. The Hospital IQR Program included 947 participating IPPS small hospitals in the FY 2021 program year.

6. Less Frequent Collection

We have designed the collection of quality measure data to be the minimum necessary for data validation and for calculation of summary figures to be used as 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.

<i>Measure Type</i>	<i>Frequency of Data Submission</i>
Chart-abstracted clinical process of care	Quarterly
EHR-based clinical process of care (i.e., eCQMs)	Annually
EHR data for hybrid measures	Annually

7. Special Circumstances

Although participation in the Hospital IQR Program is voluntary on the part of subsection (d) hospitals, all eligible hospitals must submit these data and meet all other Hospital IQR Program requirements in order to receive their full APU for the given fiscal year. If a hospital does not submit the required data and meet all other Hospital IQR Program requirements, it would be subject to a reduced APU for a given fiscal year.

8. Federal Register Notice/Outside Consultation

A 60-day *Federal Register* notice of the FY 2021 IPPS/LTCH PPS proposed rule (RIN XXXX, CMS-1735-P) is anticipated to go on display on or around April 1, 2020. Comments will be submitted on this notice, and we will respond to those comments accordingly.

CMS is supported in this initiative by The Joint Commission, National Quality Forum (NQF), Measure Applications Partnership, Centers for Disease Control and Prevention, and Agency for Healthcare Research and Quality. These organizations collaborate with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making the information accessible, understandable, and relevant to the public.

9. Payment/Gift to Respondent

No payments or gifts will be given to respondents for participation. As noted in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57261), we reimburse hospitals directly for expenses associated with submission of charts for clinical process of care measure data validation – we reimburse hospitals at 12 cents per photocopied page; for hospitals providing charts digitally via a re-writable disc, such as encrypted CD-ROM, DVD, or flash drive or via secure file transfer, we reimburse hospitals at a rate of \$3.00 per record submitted and additionally at a rate of 40 cents per disc. In the FY 2021 IPPS/LTCH PPS proposed rule, we are proposing to require the use of electronic file submissions via a CMS-approved secure file transmission process and to no longer allow the submission of paper copies of medical records or copies on digital portable media such as CD, DVD, or flash drive, beginning with validation of Hospital IQR Q1 2021 program measure data impacting the FY 2024 payment determination.

10. Confidentiality

All information collected under this initiative will be maintained in strict accordance with statutes and regulations governing confidentiality requirements for Quality Improvement Organizations, which can be found at 42 CFR 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 the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. The CMS clinical data warehouse also voluntarily meets or exceeds the HIPAA standards.

11. Sensitive Questions

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 the case-specific data. These sensitive data will not, however, be released to the public. Only hospital-specific data will be released to the public after consent has been received from the hospital for the release. The patient-specific data remaining in the CMS clinical data warehouse after the data are aggregated for release for public reporting will continue to be subject to the strict confidentiality regulations in 42 CFR Part 480.

12. Burden Estimate (Total Hours & Wages)

a. Background

For the purposes of burden estimation, we assume all of the activities associated with the Hospital IQR Program for 3,300 IPPS hospitals and 1,100 non-IPPS hospitals will be completed by Medical Records and Health Information Technicians. 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, and the submission of data to clinical registries, and

the completion of any of the other applicable forms associated with activities related to the Hospital IQR Program.

As shown in Table 1, OMB has currently approved 1,612,710 hours of burden and approximately \$62.6 million (adjusted for updated wage rates) under OMB control number 0938-1022, accounting for information collection burden experienced by approximately 3,300 IPPS hospitals and 1,100 non-IPPS hospitals for the FY 2022 payment determination. Our burden estimates exclude burden associated with the National Healthcare Safety Network under OMB control number 0920-0666, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey under OMB control number 0938-0981, and the Medicare Promoting Interoperability Program under OMB control number 0938-1158.

We are not proposing any changes to the currently approved burden estimates for chart abstraction measures (sepsis and perinatal care), Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) measure, population and sampling for ongoing measure sets, reviewing of reports for claims-based measure sets, and completion of all other forms used in the data collection process for the FY 2022 through 2026 payment determination years. Changes to currently approved burden estimates due to proposals in the FY 2021 IPPS/LTCH PPS proposed rule are discussed below.

Table 1. Currently Approved Burden Estimates for the Hospital IQR Program Measure Set and Other Activities for the FY 2022 Payment Determination

<i>Measure Set</i>	<i>Estimated time per record (minutes) - FY 2022 payment determination</i>	<i>Number reporting quarters per year - FY 2022 payment determination</i>	<i>Number of hospitals reporting</i>	<i>Average number records per hospital per quarter</i>	<i>Annual burden (hours) per hospital</i>	<i>Calculation for FY 2022 payment determination</i>
CHART ABSTRACTION						
IPPS Hospitals (3,300)						
Sepsis Measure	60	4	3,300	100	400	1,320,000
Perinatal care (PC)	10	4	3,300	76	51	167,200
Subtotal IPPS chart-based					451	1,487,200
Non-IPPS Hospitals (1,100)						
Sepsis measure	60	4	362	25	100	36,200
Perinatal care (PC)	10	4	334	21	14	4,676
Subtotal Non-IPPS chart-based					114	40,876
Subtotal IPPS and Non-IPPS chart-based						1,528,076

REPORTING eQMs						
IPPS Hospitals (3,300)						
Reporting 4 eQMs	40	1	3,300	1	0.67	2,200
Non-IPPS Hospitals (1,100)						
Reporting 4 eQMs	40	1	1,100	1	0.67	733.3
eCQM Subtotal (IPPS and Non-IPPS)					-	2,933.3
OTHER ACTIVITIES						
All Hospitals (3,300 IPPS + 1,100 non-IPPS)						
Population and sampling for the ongoing measure sets	15	4	4,400	4	4	17,600
Review reports for claims-based measure sets	60	4	4,400	1	4	17,600
HAI Validation Templates (CLABSI, CAUTI) (IPPS)	1,200	4	300	1	80	24,000
HAI Validation Templates (MRSA, CDI) (IPPS)	960	4	300	1	64	19,200
eCQM Validation	80	1	200	8	11	2,200
All other forms used in the data collection process and structural measures	15	1	4,400	1	0.25	1,100
Subtotal other activities					13.58	81,700
Total Burden Hours						1,612,710
Total Burden @ Medical Records and Health Information Technician labor rate (\$38.80/hr)						\$62,573,148

b. Updated Hourly Wage Rate

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42602 through 42605), we estimated that the labor performed could be accomplished by Medical Records and Health Information Technician staff based on a mean hourly wage in general medical and surgical hospitals of \$18.83 per hour. We note that since then, more recent wage data from the Bureau of Labor Statistics have become available, reflecting a median hourly wage of \$19.40 per hour.¹ We calculated the cost of overhead, including fringe benefits, at 100% of the mean hourly wage, consistent with previous years. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly between employers, and because methods of estimating these costs vary widely in the literature. Nonetheless, we believe that doubling the hourly wage ($\$19.40 \times 2 = \38.80) to estimate total cost is a reasonably accurate estimation method. As a result of the

¹ U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records and Health Information Technicians. Available at: <https://www.bls.gov/ooh/healthcare/medical-records-and-health-information-technicians.htm>. Accessed 17 Mar. 2020.

availability of this more recent wage data, we have updated the wage rate used in these calculations in the FY 2021 IPPS/LTCH PPS proposed rule and this corresponding PRA package to \$38.80.

c. eCQM Reporting and Submission Requirements for the CY 2021 Reporting Period/FY 2023 Payment Determination, the CY 2022 Reporting Period/FY 2024 Payment Determination, and the CY 2023 Reporting Period/FY 2025 Payment Determination and Subsequent Years

In the FY 2020 IPPS/LTCH PPS final rule, we finalized eCQM reporting and submission requirements such that hospitals submit one, self-selected calendar quarter of data for four eCQMs for the CYs 2020 and 2021 reporting periods/FYs 2022 and 2023 payment determinations (84 FR 42503) and one, self-selected calendar quarter of data for three self-selected eCQMs and the Safe Use of Opioids—Concurrent Prescribing eCQM for the CY 2022 reporting period/FY 2024 payment determination (84 FR 42505). Our related information collection estimates were discussed at 84 FR 42604.

In the FY 2021 IPPS/LTCH PPS proposed rule, we are proposing to progressively increase the number of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data over a three year period, by requiring hospitals to report: (1) two quarters of data for the CY 2021 reporting period/FY 2023 payment determination, while continuing to require hospitals to report four self-selected eCQMs; (2) three quarters of data for the CY 2022 reporting period/FY 2024 payment determination, while continuing to report three self-selected eCQMs and the Safe Use of Opioids eCQM; and (3) four quarters of data beginning with the CY 2023 reporting period/FY 2025 payment determination and for subsequent years, while continuing to require hospitals to report three self-selected eCQMs and the Safe Use of Opioids—Concurrent Prescribing eCQM. We believe there would be a progressive increase to the burden estimate over the three year period due to these proposed policies.

Referring to the burden estimates currently approved by OMB shown in Table 1, we previously estimated the information collection burden associated with the eCQM reporting and submission requirements to be 40 minutes per hospital per year (10 minutes x 4 eCQMs x 1 quarter = 40 minutes), or 0.67 hours per hospital per year (40 minutes / 60 = 0.67 hours). We estimated a total annual burden of 2,200 hours across all IPPS hospitals (0.67 hours x 3,300 IPPS hospitals) for each quarter of eCQM data.

In Table 2, using the updated wage estimate described above, we estimate this to represent a total additional annual cost of \$85,360 (\$38.80 hourly wage x 2,200 annual hours) across all IPPS hospitals per each additional quarter of data. Based on our proposal to progressively increase the number of quarters of data reported, from one self-selected quarter of data to four quarters of data over a 3-year period, we estimate an annual burden increase of 2,200 hours and \$85,360 each year for each additional quarter for all participating IPPS hospitals.

For the CY 2021 reporting period/FY 2023 payment determination, there would be an increase of 2,200 hours to a total of 4,400 burden hours for reporting 2 quarters of eCQM data. For the

CY 2022 reporting period/FY 2024 payment determination, there would be an increase of 2,200 hours to a total of 6,600 hours for reporting 3 quarters of eCQM data. For the CY 2023 reporting period/FY 2025 payment determination, there would be an increase of 2,200 hours to a total of 8,800 hours for reporting 4 quarters of eCQM data. There would be a total increase of 6,600 hours (2,200 hours + 2,200 hours + 2,200 hours) and \$256,080 (\$85,360 + \$85,360 + \$85,360) across a 3-year period for all participating IPPS hospitals.

Table 2. Estimated Burden for the eCQM Reporting and Submission Requirements for the FY 2023 through FY 2026 Payment Determination Years

<i>eCQM Measure Reporting</i>	<i>Estimated time per record (minutes)</i>	<i>Number reporting quarters per year</i>	<i>Number of hospitals reporting</i>	<i>Average number records per hospital per quarter</i>	<i>Annual burden (hours) per hospital</i>	<i>Total Annual Hours for all hospitals</i>
FY 2023 Payment Determination						
Reporting 4 eCQMs (IPPS Hospitals)	40	2	3,300	1	1.33	4,400
Reporting 4 eCQMs (Non-IPPS Hospitals)	40	2	1,100	1	1.33	1,466.7
Total Burden Hours						5,866.7
Total Burden @ Medical Records and Health Information Technician labor rate (\$38.80/hr)						\$227,627
FY 2024 Payment Determination						
Reporting 4 eCQMs (IPPS Hospitals)	40	3	3,300	1	2.0	6,600
Reporting 4 eCQMs (Non-IPPS Hospitals)	40	3	1,100	1	2.0	2,200
Total Burden Hours						8,800
Total Burden @ Medical Records and Health Information Technician labor rate (\$38.80/hr)						\$341,440
FY 2025 Payment Determination						
Reporting 4 eCQMs (IPPS Hospitals)	40	4	3,300	1	2.67	8,800
Reporting 4 eCQMs (Non-IPPS Hospitals)	40	4	1,100	1	2.67	2,933.3
Total Burden Hours						11,733.3
Total Burden @ Medical Records and Health Information Technician labor rate (\$38.80/hr)						\$455,253
FY 2026 Payment Determination						
Reporting 4 eCQMs (IPPS Hospitals)	40	4	3,300	1	2.67	8,800
Reporting 4 eCQMs (Non-IPPS Hospitals)	40	4	1,100	1	2.67	2,933.3
Total Burden Hours						11,733.3

Total Burden @ Medical Records and Health Information Technician labor rate (\$38.80/hr)	\$455,253
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d. eCQM Public Display Requirements Beginning with the CY 2021 Reporting Period/FY 2023 Payment Determination

In the FY 2021 IPPS/LTCH PPS proposed rule, we are proposing to begin public display of eCQM data beginning with data reported by hospitals for the CY 2021 reporting period and for subsequent years. Because hospitals would not have any additional information collection requirements, we believe there would be no change to the burden estimate due to this policy.

e. Updates to the Processes for Validation of Hospital IQR Program Measure Data

In the FY 2021 IPPS/LTCH PPS proposed rule, we are proposing to make several changes to streamline the validation process. First, we are proposing to require the use of electronic file submissions via a CMS-approved secure file transmission process, no longer allowing the submission of paper copies of medical records or copies on digital portable media such as CD, DVD, or flash drive, beginning with validation of Q1 2021 data impacting the FY 2024 payment determination. Second, we are proposing to align the validation processes for chart-abstracted measures and eQMs by: (a) aligning data submission quarters, with the validation quarters for the FY 2023 payment determination serving as a transition year before being fully aligned as to validation quarters beginning with the FY 2024 payment determination; (b) aligning hospital selection, including: (i) reducing the pool of hospitals randomly selected for chart-abstracted measure validation, and (ii) integrating and applying targeting criteria for eCQM validation, beginning with validation for the FY 2024 payment determination; and (c) aligning scoring processes by providing one combined validation score for the validation of chart-abstracted measures and eQMs with the eCQM portion of the combined score weighted at zero, beginning with validation for the FY 2024 payment determination. Lastly, we are proposing to formalize the process for conducting educational reviews for eCQM validation in alignment with current processes for providing feedback for chart-abstracted validation results, beginning with eCQM validation for the FY 2023 payment determination.

As noted in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57261), we reimburse hospitals directly for expenses associated with submission of medical records for data validation; specifically, we reimburse hospitals at 12 cents per photocopied page; 40 cents per disc, along with \$3.00 per record for hospitals providing medical records digitally via a rewritable disc, such as encrypted CD-ROMs, DVDs, or flash drives; and \$3.00 per record for hospitals providing medical records as electronic files submitted via secure file transmission. In addition, in the FY 2017 IPPS/LTCH IPPS final rule (81 FR 57261), we finalized, for eCQM validation, reimbursement of \$3.00 per record to hospitals that provide medical records as electronic files submitted via secure file transmission (paper copies and digital portable media are not accepted for eCQM validation). Because of this direct reimbursement, we do not anticipate any net change in information collection burden associated with our proposal to require electronic file submissions of medical records via secure file transmission for hospitals selected for chart-abstracted measures validation; hospitals would continue to be reimbursed at \$3.00 per record.

Similarly, because we directly reimburse hospitals, we do not anticipate any net change in information collection burden associated with our proposals to align the data submission quarters, to align the hospital selection process by reducing the pool of hospitals randomly selected for validation for chart-abstracted measures from 400 hospitals to up to 200 hospitals, or to align the scoring processes to provide one combined validation score for the validation of chart-abstracted measures and eCQMs. In addition, we do not anticipate any information collection burden associated with our proposal to formalize the process for conducting educational reviews for eCQM validation. As discussed in section VIII.A.11.b.(3) of the FY 2021 IPPS/LTCH PPS proposed rule, this process would allow any validated hospital to request an educational review of their eCQM validation results with CMS.

We previously estimated the information collection burden associated with eCQM validation to be 80 minutes per record, or 11 hours per hospital per year (80 minutes per record \times 8 records \times 1 quarter / 60 = 10.67 hours) (81 FR 57261). We estimated a total annual burden of approximately 2,200 hours across 200 IPPS hospitals selected for eCQM validation each year (11 hours \times 200 IPPS hospitals). Using the updated wage estimate as described above, we estimate this to represent a total annual cost of \$85,360 (\$38.80 hourly wage \times 2,200 annual hours) across 200 IPPS hospitals.

The estimate of 80 minutes per record was based on our limited experience working with voluntary hospital participants during the eCQM validation pilot conducted in 2015 (79 FR 50269 through 50272). For the validation pilot, participating hospitals attended a 30-minute pre-briefing session and had to install CMS-approved software that allowed our Clinical Data Abstraction Center (CDAC) contractor to remotely view isolated records in real-time under hospital supervision in order to compare all abstracted data with QRDA Category I file data and summarize the results of the real-time session (79 FR 50270). Since this 2015 pilot, the eCQM validation process that we have implemented under the Hospital IQR Program has been significantly streamlined so that we no longer need hospitals to allow remote access to the CDAC contractor to view records in real-time under each hospital's supervision nor for them to engage in discussions with our contractor during the process. Instead, hospitals selected for eCQM validation are only required to submit timely and complete copies of medical records on eCQMs selected for validation to CMS by submitting records in PDF file format within 30 calendar days following the medical records request date listed on the CDAC request form via the QualityNet secure file transmission process (81 FR 57179).

Based on this updated process, as well as hospitals having gained several years of experience using EHRs, we are revising our previous estimate from 80 minutes per record to 10 minutes per record. This is the amount of time we estimate is needed for hospitals to create PDF files and to electronically submit each medical record via the CMS-approved secure file transmission process. The estimate of 10 minutes per record is similar to our estimate of 10 minutes per eCQM per quarter in submitting QRDA Category I files via the QualityNet secure portal (81 FR 57260). We note that as mentioned above, hospitals will still be reimbursed at \$3.00 per record (81 FR 57261).

In addition, we anticipate that our proposal to progressively increase the number of quarters of eCQM data reported, from one self-selected quarter of data to four quarters of data over a three

year period, would similarly increase the total number of quarters of data from which cases would be selected for eCQM validation over a three year period. Our proposal to align the hospital selection process such that the Hospital IQR Program would validate a pool of up to 400 hospitals across measure types (up to 200 hospitals would be randomly selected and up to 200 hospitals would be selected using targeting criteria) would increase the number of hospitals selected for eCQM validation from up to 200 hospitals to up to 400 hospitals.

Therefore, as shown in Table 3, we estimate the following burden changes over a three year period using the revised estimate of 10 minutes (0.167 hours) per record as discussed above. For eCQM validation of CY 2021 data impacting the FY 2024 payment determination, we estimate a total burden of 1,067 hours across 400 IPPS hospitals selected for eCQM validation (0.167 hours × 2 quarters × 8 cases × 400 IPPS hospitals) at a cost of \$41,387 (\$38.80 hourly wage × 1,067 annual hours). This reflects a total burden decrease of 1,133 hours (2,200 hours – 1,067 hours) and \$43,973 (\$85,360 - \$41,387) compared to our previous burden estimate for eCQM validation for the FY 2024 payment determination. For eCQM validation of CY 2022 data impacting the FY 2025 payment determination, we estimate a total burden of 1,600 hours across 400 IPPS hospitals selected for eCQM validation (0.167 hours × 3 quarters × 8 cases × 400 IPPS hospitals) at a cost of \$62,080 (\$38.80 hourly wage × 1,600 annual hours). This reflects a total burden decrease of 600 hours (2,200 hours – 1,600 hours) and \$23,280 (\$85,360 - \$62,080) compared to our previous burden estimate for eCQM validation for the FY 2025 payment determination. For eCQM validation of CY 2023 data impacting the FY 2026 payment determination, and for subsequent years, we estimate a total burden of 2,133 hours across 400 IPPS hospitals selected for eCQM validation (0.167 hours × 4 quarters × 8 cases × 400 IPPS hospitals) at a cost of \$82,773 (\$38.80 hourly wage × 2,133 annual hours). This reflects a total burden decrease of 67 hours (2,200 hours – 2,133 hours) and \$2,587 (\$85,360 - \$82,773) compared to our previous burden estimate for eCQM validation for the FY 2026 payment determination and subsequent years.

Table 3. Estimated Burden for the Validation of Hospital IQR Program Measure Data for the FY 2024 through FY 2026 Payment Determination Years

<i>Validation of Hospital IQR Program Measure Data (eCQM Validation)</i>	<i>Estimated time per record (minutes)</i>	<i>Number reporting quarters per year</i>	<i>Number of hospitals reporting</i>	<i>Average number records per hospital per quarter</i>	<i>Annual burden (hours) per hospital</i>	<i>Total Annual Hours for all hospitals</i>
FY 2024 Payment Determination						
Total Burden (IPPS Hospitals)	10	2	400	8	2.67	1066.7
Total Burden @ Medical Records and Health Information Technician labor rate (\$38.80/hr)						\$41,387
FY 2025 Payment Determination						
Total Burden (IPPS Hospitals)	10	3	400	8	4	1,600

Total Burden @ Medical Records and Health Information Technician labor rate (\$38.80/hr)						\$62,080
FY 2026 Payment Determination						
Total Burden (IPPS Hospitals)	10	4	400	8	5.33	2133.3
Total Burden @ Medical Records and Health Information Technician labor rate (\$38.80/hr)						\$82,773

f. Additional Information on Burden Estimates

Time estimates for activities other than abstracting charts, including completion of the forms listed below other than the HAI Validation Templates, routine reporting of population and sampling numbers for ongoing chart-abstracted measures, and review of reports were made in consultation with our Hospital IQR Program support contractor, which is responsible for routine interface with hospitals and Quality Improvement Organizations regarding Hospital IQR Program requirements. We define “*all other forms used in the data collection process*” as the forms listed below. Consistent with estimates in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49762), we estimate a burden of 15 minutes per hospital to complete all applicable forms.

Other than the DACA form, the forms listed in section B.12.k would not be filled out by hospitals on a regular basis. Because the CMS Quality Reporting Program Extraordinary Circumstances Exceptions (ECE) Request Form would be used across ten quality programs (Hospital IQR Program, Hospital Outpatient Quality Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Hospital VBP Program, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, End Stage Renal Disease Quality Incentive Program, and Skilled Nursing Facility Value-Based Purchasing 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 2017, 166 ECE requests were submitted by hospitals for an exception from reporting requirements in the Hospital IQR Program. Based on our estimation of 15 minutes per record to submit the ECE Request Form, the total burden calculation for the submission of 166 ECE requests was 2,490 minutes (or 41.5 hours) across 3,300 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 1 above) of 1,100 hours across all IPPS and non-IPPS hospitals, thus this 41.5 hours ECE Request Form burden estimation is accounted for in that figure.

g. Burden Estimate Summary

As shown in Tables 4 and 5, in summary, under OMB control number 0938-1022, we estimate a total information collection burden increase for 3,300 IPPS hospitals of 6,533 hours (6,600 hours - 67 hours) associated with our proposed policies and updated burden estimates described above and a total cost increase related to this information collection of approximately \$253,480 (\$38.80 hourly wage × 6,533 hours) (which also reflects use of an updated hourly wage rate as previously discussed), across a four-year period from the CY 2021 reporting period/FY 2023 payment determination through the CY 2024 reporting period/FY 2026 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 2026 payment determination reflects the cumulative burden changes).

**Table 4. Summary of Annual Burden Hour Estimates for the FY 2022 through FY 2026
Payment Determination Years**

Information Collection	ANNUAL BURDEN HOURS							
	FY2022	FY2023	Difference from Currently Approved	FY2024	Difference from Currently Approved	FY2025	Difference from Currently Approved	FY2026
Chart Abstraction								
IPPS	1,487,200	1,487,200	0	1,487,200	0	1,487,200	0	1,487,200
Non-IPPS	40,876	40,876	0	40,876	0	40,876	0	40,876
Hybrid Measures*								
IPPS								
Hybrid HWR	0	0	0	2,211	0	2,211	0	2,211
Non-IPPS								
Hybrid HWR	0	0	0	737	0	737	0	737
Reporting eQMs								
IPPS	2,200	4,400	+2,200	6,600	+4,400	8,800	+6,600	8,800
Non-IPPS	733.3	1,466.7	+733.3	2,200	+1,466.7	2,933.3	+2,200	2,933.3
Population and sampling for the ongoing measure sets	17,600	17,600	0	17,600	0	17,600	00	17,600
Review reports for claims-based measure sets	17,600	17,600	0	17,600	0	17,600	0	17,600
HAI Validation Templates (CLABSI, CAUTI) (IPPS)**	24,000	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HAI Validation Templates (MRSA, CDI) (IPPS)**	19,200	N/A	N/A	N/A	N/A	N/A	N/A	N/A
eCQM Validation	2,200	2,200	0	1,066.7	-1,133.3	1,600	-800	2,133.3
All other forms used in the data collection process and structural measures	1,100	1,100	0	1,100	0	1,100	0	1,100
TOTAL	1,612,709	1,572,443	-40,266	1,577,191	-35,518	1,580,658	-32,051	1,581,191

* Burden associated with the Hybrid Hospital-Wide All-Cause Readmission Measure was previously finalized in the FY 2020 IPPS/LTCH PPS final rule.

**As finalized in the FY 2019 IPPS/LTCH PPS final rule, the FY 2022 payment determination will be the last year for which the CLABSI, CAUTI, MRSA, and CDI measures will be validated under the Hospital IQR Program, and validation of those measures will transfer to the HAC Reduction Program beginning with FY 2023 (83 FR 41483).

Table 5. Summary of Annual Burden Estimates for the FY 2022 through FY 2026 Payment Determination Years

	ANNUAL BURDEN COST								
Information Collection	FY2022 (Currently Approved)	FY2023	Difference from Currently Approved	FY2024	Difference from Currently Approved	FY2025	Difference from Currently Approved	FY2026	Difference from Currently Approved
Chart Abstraction									
IPPS	\$57,703,360	\$57,703,360	0	\$57,703,360	0	\$57,703,360	0	\$57,703,360	0
Non-IPPS	\$1,585,989	\$1,585,989	0	\$1,585,989	0	\$1,585,989	0	\$1,585,989	0
Hybrid Measures									
IPPS									
Hybrid HWR	0	0	0	\$85,787	+\$85,787	\$85,787	+\$85,787	\$85,387	+\$85,787
Non-IPPS									
Hybrid HWR	0	0	0	\$28,595	+\$28,595	\$28,595	+\$28,595	\$28,595	+\$28,595
Reporting eCQMs									
IPPS	\$85,360	\$170,720	+\$85,360	\$256,080	+\$170,720	\$341,440	+\$256,080	\$341,440	+\$256,080
Non-IPPS	\$28,453	\$56,907	+\$28,454	\$85,360	+\$56,907	\$113,813	+\$85,360	\$113,813	+\$85,360
Population and sampling for the ongoing measure sets	\$662,816	\$682,880	+\$20,064	\$682,880	+\$20,064	\$682,880	+\$20,064	\$682,880	+\$20,064
Review reports for claims-based measure sets	\$662,816	\$682,880	+\$20,064	\$682,880	+\$20,064	\$682,880	+\$20,064	\$682,880	+\$20,064
HAI Validation Templates (CLABSI, CAUTI) (IPPS)	\$931,200	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HAI Validation Templates (MRSA, CDI) (IPPS)	\$744,960	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
eCQM Validation	\$85,360	\$85,360	0	\$41,387	-\$43,973	\$62,080	-\$23,280	\$82,773	-\$2,587
All other forms used in the data collection process and structural measures	\$42,680	\$42,680	0	\$42,680	0	\$42,680	0	\$42,680	0
TOTAL	\$62,573,122	\$61,010,788	\$113,814	\$61,194,429	\$183,654	\$61,442,749	\$431,973	\$61,463,441	\$509,573

h. *Information Collection Instruments/Instructions*

- Hospital Inpatient Quality Reporting Notice of Participation (Revised).
 - Form resubmitted to change references to Hospital Compare to the public reporting website and to specify the use of optional quality measure data for publicly reporting summary information such as star ratings.
- Hospital Quality Reporting Data Accuracy and Completeness Acknowledgement (DACA) (Revised).
 - Form resubmitted to reflect updated list of measures.
- Request Form for Withholding/Footnoting Data for Public Reporting (Revised)
 - Form resubmitted to change references to Hospital Compare to the public reporting website, updated the measure tables, and provided clarification related to the withholding of public reporting for the star ratings for those hospitals with an optional public reporting notice of participation.
- Centers for Medicare & Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) Quality Reporting Programs Measure Exception Form for PC and HAI Data Submission (Revised).
 - No updates/changes to previously submitted form. Form still in use. Will need to update the reference to the *QualityNet Secure Portal*.
- CMS Quality Reporting Program APU Reconsideration Request Form (Revised)
 - Updated reference to Security Administrator to Security Administrator/Official and to more clearly delineate signature area. Form still in use.
- CMS Hospital IQR Program Validation Review for Reconsideration Request Form (Revised)
 - Form resubmitted to remove the inapplicable columns (i.e., Measure Set as the only measure is now sepsis and NHSN Event ID Number for HAI Measures as they are no longer in the IQR program), add a column for Discharge Quarter, and clarify the Element Name column. Additionally, a line was added for the submitters email address. Will need to update the reference to the *QualityNet Secure Portal*.
- CMS Quality Program Extraordinary Circumstances Exceptions (ECE) Request Form (Revised)
 - Form resubmitted to clarify instructions, list Population and Sampling to the Data Requirement(s) Affected section, and to update the email address for the SNF VBP program. Will need to update the reference to the *QualityNet Secure Portal*.
- CMS Quality Reporting Validation Educational Review Form (Revised)
 - Updated to add applicability of the form for HAI validation under the Hospital-Acquired Condition Reduction Program.
- Hospital Value-Based Purchasing (VBP) Program Review and Corrections Request Form (Revised)
 - Updated reference to Security Administrator to Security Administrator/Official. Will need to update the reference to the *QualityNet Secure Portal*.

- Hospital Value-Based Purchasing (VBP) Program Appeal Request Form (Revised)
 - Updated reference to Security Administrator to Security Administrator/Official. Will need to update the reference to the *QualityNet Secure Portal*.
- Hospital Value-Based Purchasing (VBP) Program Independent CMS Review Request Form (Revised)
 - Updated reference to System Administrator to Security Administrator/Official. Will need to update the reference to the *QualityNet Secure Portal*.

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs.

14. Cost to Federal Government

The cost to the Federal Government includes costs associated with the collection and validation of the data. 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 level with approximate annual salaries of \$102,663 per staff member to operate for an additional cost of \$307,989.

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 2020 reporting period/FY 2022 payment determination of 1,612,710 hours at a total cost of approximately \$62.6 million (accounting for updated wage rates) as a result of policies finalized in the FY 2020 IPPS/LTCH PPS final rule.

For the CY 2021 reporting period/FY 2023 payment determination, we anticipate the total annual burden estimate to be 1,572,443 hours at a cost of approximately \$61 million. This change in burden is associated with the policy proposed in the FY 2021 IPPS/LTCH proposed rule to increase the number of reporting quarters for eCQMS from one to two quarters and the previously finalized policy in the FY 2019 IPPS Final Rule (83 FR 41478-83 FR 41484) to move the validation of HAI measures to the HACRP program that takes effect in CY 2021. The increase in reporting quarters from one quarter to two quarters between CY 2020 and CY 2021 is associated with a 2,933 hour increase in burden across IPPS and Non-IPPS hospitals. The removal of HAI measure validation from the IQR program is associated with a 43,200 hour reduction of burden. Those two changes result in a net 40,267 hour reduction in burden. The

burden cost from CY 2020 to CY 2021 decreased from approximately \$62.6 million to \$61 million.

16. Publication/Tabulation Data

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 IQR Program, 1886(o)(10) for the Hospital VBP Program, 1886(p)(6) for the HAC Reduction Program, and 1886(q)(6) for the Hospital Readmissions Reduction Program. Hospital data from these initiatives are currently used to populate the *Hospital Compare* website, <https://www.medicare.gov/hospitalcompare/search.html?>, or its successor website(s). Data are presented on *Hospital Compare* 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 *Hospital Compare* in performance categories of Better, No Different, or Worse than the National Rate. More detailed measure data, including the data used for *Hospital Compare*, are also available to the public as downloadable files at <https://data.medicare.gov>. Hospital quality data on *Hospital Compare* are currently updated on a quarterly basis.

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 our *QualityNet* website (www.qualitynet.org). We will also display the approved expiration date prominently on our *QualityNet* website's Hospital IQR 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.