

Supporting Statement – Part A

Submission of Information for the Hospital Outpatient Quality Reporting (OQR) Program: CY 2021 OPPTS/ASC Proposed Rule

A. Background

The Centers for Medicare and Medicaid Services' (CMS') quality reporting programs promote higher quality, more efficient healthcare for Medicare beneficiaries by increasing transparency through public reporting of quality of care metrics; this information is made available to inform consumers and to incentivize healthcare facilities to make continued improvements. CMS has implemented quality measure reporting programs for multiple settings, including for hospital outpatient departments (HOPDs).

The CMS quality reporting program established for the HOPD setting is referred to the Hospital Outpatient Quality Reporting (OQR) Program. As required, CMS has adopted quality of care measures for the HOPD setting; data collection under this program began calendar year 2008. As required by mandating statute, these data have been made publicly available after providing hospitals the opportunity to review the data.

The information collection requirements for the CY 2014 through CY 2022 payment determinations are approved under OMB Control Number 0938-1109. This information collection request covers the existing measure sets to be collected for the CY 2022 through CY 2025 payment determinations.

B. Justification

1. Need and Legal Basis

A quality reporting program for hospital outpatient departments was mandated by the Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109-432) Section 109(a) amended Section 1833(t) of the Social Security Act (the Act) by adding a new subsection (17) that affects the payment rate update applicable to Outpatient Prospective Payment System (OPPS) payments for services furnished by hospitals in outpatient settings on or after January 1, 2009.

Section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under Section 1886(d)(1)(B) of the Act, states that hospitals that fail to report data required for quality measures selected by the Secretary in the form and manner required by the Secretary under Section 1833(t)(17)(B) of the Act will incur a reduction in their annual payment update (APU) factor to the hospital outpatient department fee schedule of 2.0 percentage points.

Sections 1833(t)(17)(C)(i) and (ii) of the Act require the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings. Such measures must reflect consensus among affected parties and, to the extent feasible

and practicable, must be set forth by one or more national consensus building entities. The Secretary also has the authority to replace measures or indicators as appropriate. The Act also requires the Secretary to establish procedures for making the data submitted available to the public. Such procedures must provide the hospitals the opportunity to review such data prior to public release.

CMS has adopted quality measures, administrative processes, and data submission requirements for the CYs 2014 through 2021 payment determinations through the following rulemaking: CY 2012 OPSS/ASC final rule with comment period (76 FR 74458 through 74472); CY 2013 OPSS/ASC final rule with comment period (77 FR 68481 through 68484); CY 2014 OPSS/ASC final rule with comment period (78 FR 75096 through 75104; 78 FR 75111 through 75112); CY 2015 OPSS/ASC final rule with comment period (79 FR 66944 through 66956; 79 FR 66984 through 66985); CY 2016 OPSS/ASC final rule with comment period (80 FR 70507 through 70511; 80 FR 70519 through 70520); CY 2017 OPSS/ASC final rule with comment period (81 FR 79753 through 79796); CY 2018 OPSS/ASC final rule with comment period (82 FR 59424 through 59445); CY 2019 OPSS/ASC final rule with comment period (83 FR 59080 through 59110); and CY 2020 OPSS/ASC final rule with comment period (83 FR 61410 through 61419). The information collection requirements for the CY 2014 through CY 2022 payment determinations are currently approved under OMB Control Number 0938-1109.

1.a. Data Collection

Table 1 outlines the Hospital OQR Program measure set as finalized through prior rulemaking. We are not proposing to remove or adopt any program measures in the CY 2021 OPSS/ASC proposed rule with comment period.

Table 1. Previously-Finalized Hospital OQR Program Measures for the CY 2022 Payment Determination

Short Name	Measure Name	NQF No.
Chart-Abstracted Measures		
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of emergency department Arrival	0288
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290
OP-18	Median Time from ED Arrival to ED Departure for Discharged ED Patients	0496
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of emergency department Arrival	0661
Claims-Based Measures		
OP-8	MRI Lumbar Spine for Low Back Pain	0514
OP-10	Abdomen CT Use of Contrast Material	N/A

Short Name	Measure Name	NQF No.
OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	0669
OP-32	Colonoscopy Measure: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	2539
OP-35	Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy	N/A
OP-36	Risk-standardized Hospital Visits within 7 Days after Hospital Outpatient Surgery	2687
Web-Based Measures		
OP-22	Patient Left Without Being Seen	0499
OP-29	Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	0658
OP-31	Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	1536
Survey-Based Measures		
OP-37a-e	OAS CAHPS Survey OP-37a: About Facilities and Staff * OP-37b: Communication about Procedure * OP-37c: Preparation for Discharge and Recovery * OP-37d: Overall Rating of Facility * OP-37e: Recommendation of Facility *	N/A

* Measure delayed beginning with the CY 2020 payment determination (CY 2018 data collection) until further action in future rulemaking. Survey administration burdens for this measure are captured under a previously finalized PRA Package, OMB Control Number 0938-1240.

There are three modes of data submission utilized under the Hospital OQR Program: (1) chart-abstracted measures, which require the submission of patient-level information obtained through chart abstraction that is then submitted electronically to CMS; (2) web-based measures, which require hospitals to chart-abstract and then submit non-patient level data directly to CMS via the CMS web-based tool (QualityNet Website); and (3) claims-based measures, which are derived through analysis of administrative claims data and do not require additional effort or burden on hospitals.

1.b. Forms Used in Hospital OQR Program Procedures

To administer the Hospital OQR Program, three forms are utilized: (1) Validation Review; (2) Extraordinary Circumstances Exception (ECE) Request; and (3) Reconsideration Request. None of these forms are completed on an annual basis; all are on a need-to-use, exception basis and

most hospitals will not need to complete any of these forms in any given year. Thus, the burden for providers associated with forms utilized in the Hospital OQR Program is nominal.

(1) Validation Review Form

CMS performs a random and targeted selection of Outpatient Prospective Payment Systems (OPPS) hospitals on an annual basis. The selection includes up to 500 hospitals including 450 randomly selected hospitals and up to 50 targeted hospitals. In the event that CMS determines that a hospital did not meet any of the Hospital OQR Program requirements due to a confidence interval validation score of less than 75 percent, the hospital may complete and submit the Validation Review form.

(2) Extraordinary Circumstances Exception (ECE) Request Form

In the event of extraordinary circumstances not within the control of the hospital, such as a natural disaster, a hospital can request an exception from meeting program requirements. For the hospital to receive consideration for an exception, an Extraordinary Circumstances Exception Request must be submitted.¹ This form can be found online and can be submitted electronically, by mail, or by fax. We note that the burden associated with completing and submitting this form is already accounted for under a separate PRA Package, OMB Control Number 0938-1022 and, therefore, is not accounted for in this PRA Package.

(3) Reconsideration Request Form

When CMS determines that a hospital has not met program requirements and receives a 2.0 percentage point reduction in its annual percentage update, hospitals may submit a Reconsideration Request to CMS. The request must be submitted no later than the first business day on or after March 17 of the affected payment year. This form can be found on the QualityNet website; it can be submitted via Secure File Transfer using the QualityNet Secure Portal or via secure fax. While there is burden associated with filing a Reconsideration Request, regulations under the Paperwork Reduction Act of 1995, 5 C.F.R. § 1320.4, exclude collection activities during the conduct of administrative actions such as reconsiderations. Therefore, the burden associated with submitting a Reconsideration Request is not accounted for in this PRA package.

2. Information Users

While the statutory authority of the Hospital OQR Program is focused on the collection and public reporting of quality data, these data have many uses beyond public reporting. Most importantly, the information collected under the Hospital OQR Program is available to Medicare beneficiaries and other consumers on the Hospital Compare website to assist them in making decisions about their healthcare.

¹ We note that this process was previously referred to as an Extraordinary Circumstances “Extension/Exemption” Request. However, in the CY 2018 OPPS/ASC final rule with comment period, we noted our intent to begin referring to the process as the Extraordinary Circumstances Exception process.

The measure information collected can also be used by hospitals for their use in internal quality improvement initiatives, helping identify best practices, improve the cost effectiveness of care, and better focus on providing patient-centered care to all patients.

CMS uses this information to direct its contractors, such as QIN-QIOs, to focus on particular areas of improvement and to develop quality improvement initiatives. For example, facility specific reports generated from program claims-based measures are distributed to Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) to use in developing and refining their quality improvement initiatives which seek to improve quality of care through education, outreach, and sharing best practices.

The Hospital OQR Program also supports other federal quality of care efforts; data collected for OP-2, OP-3, OP-18, and OP-22 are included in the Medicare Beneficiary Quality Improvement Project (MBQIP), a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program of the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP). The goal of MBQIP is to improve the quality of care provided in critical access hospitals (CAHs) by increasing quality data reporting by CAHs and then driving quality improvement activities based on the data. The MBQIP provides an opportunity for individual hospitals to look at their own data, measure their outcomes against other CAHs and partner with other hospitals in the state around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients.²

Also, under Section 3014 of the ACA, 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 data from the Hospital OQR Program and other CMS programs, CMS' findings were formally written into the latest triennial National Impact Assessment Report, which was released in February 2018.³

3. Use of Information Technology

To assist hospitals in this initiative, CMS employs the use of an established, free data collection tool, the CMS Abstraction and Reporting Tool (CART). In addition, CMS provides a secure data warehouse and use of the QualityNet website for storage and transmittal of data as well as data validation and aggregation services prior to the release of data to the CMS website. Hospitals also have the option of using vendors to transmit the data. CMS has engaged a national support contractor to provide technical assistance with the data collection tool, other program requirements, and to provide education.

This section is not applicable to claims-based measures since they are calculated from administrative claims data that result from claims submitted by hospitals to Medicare for

² For additional details about the MBQIP project, please visit: www.ruralcenter.org/tasc/mbqip.

³ The latest 2018 Impact Assessment Report, as well as earlier reports from 2012 and 2015, may be found at: 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.html.

reimbursement. Therefore, no additional information technology will be required for hospitals for these measures.

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect quality of care data for outpatient hospital care. As required by statute, CMS requires hospitals to submit quality measure data for services provided in the outpatient setting.

Hospitals are required to complete and submit a written form on which they agree to participate in the Hospital OQR Program. This declaration remains in effect, even as the measure set changes, until such time as a hospital specifically elects to withdraw.

5. Small Business

Information collection requirements are designed to allow maximum flexibility, specifically to small hospitals wishing to participate in hospital reporting. This effort will assist small hospitals in gathering information for their own quality improvement efforts.

6. Less Frequent Collection

CMS has designed the collection of quality of care data to be the minimum necessary for data validation and calculation of summary figures to be reliable estimates of hospital performance. Under the Hospital OQR Program, hospitals are required to submit chart-abstracted measures to CMS on a quarterly basis, and are required to submit web-based measures to CMS on an annual basis. In addition, for submission of claims-based measures, hospitals are required to submit paid Medicare FFS claims data for services from a 12-month period from July three years before the payment determination through June of the following year. CMS collects the data submitted by hospitals from the chart-abstracted measures, web-based measures, and claims-based measures to determine the annual payment updates to hospitals, which are decided on a yearly basis. To collect the information less frequently would compromise the timeliness of any calculated estimates.

7. Special Circumstances

All subsection (d) hospitals reimbursed under the OPSS must meet Hospital OQR Program Requirements, including administrative, data submission, and validation requirements to receive the full OPSS payment update for the given calendar year. Failure to meet all requirements may result in a 2.0 percentage point reduction in the annual payment update.

8. Federal Register Notice/Outside Consultation

The CY 2021 OPSS/ASC proposed rule was published on August 12, 2020 (85 FR 48772).

CMS is supported in this program's efforts by The Joint Commission, National Quality Forum (NQF), Measures Application Partnership (MAP), and the Centers for Disease Control and Prevention (CDC). These organizations collaborate with CMS on an ongoing basis, providing technical assistance in developing and identifying quality measures, and assisting in making collected information accessible, understandable, and relevant to the public.

9. Payment/Gift to Respondent

Hospitals are required to submit this data in order to receive the full OPPTS annual payment update. No other payments or gifts will be given to hospitals for participation.

10. Confidentiality

All information collected under the Hospital OQR 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. Data related to the Hospital OQR Program is housed in the Hospital Quality Reporting (HQR) application group. HQR is a part of the QualityNet which is a General Support System (GSS) housing protected health information (PHI). Users who access QualityNet are identity-managed to permit access the system and have role-based restrictions (including log-in and password) to the data they can see. The System of Records Notice (SORN) in use for the quality programs including the Hospital OQR Program is MBD 09-70-0536.

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 subsequent improvement activities and cannot be calculated without the case specific data. Case-specific data will not be released to the public and are not releasable by requests under the Freedom of Information Act. Only hospital-specific data will be made publicly-available as mandated by statute. In addition, the tools used for transmission of data are considered confidential forms of communication and are HIPAA-compliant.

12. Burden Estimate (Total Hours & Wages)

We are not proposing the removal or addition of any measures to the Hospital OQR Program measure set in the CY 2021 OPPTS/ASC proposed rule. For the Hospital OQR Program, the burden associated with meeting program requirements includes the time and effort associated with: (1) completing administrative requirements; (2) collecting and reporting data on the required measures under the Hospital OQR Program; and (3) submitting documentation for validation purposes.

12.a. Previously Finalized Measures Burden Summaries

Our burden estimates are calculated based on the following:

- Unless otherwise specified, we estimate a total of 3,164 hospitals participating in the Hospital OQR Program.⁴
- In the CY 2021 OPPS/ASC proposed rule, we are not proposing any measure additions or removals to the Hospital OQR Program measure set for the CY 2023 payment determination and subsequent years; thus, our estimates for the hourly burden associated with all measure types remain the same as those previously approved for the CY 2023 payment determination under this OMB Control Number
- We estimate that collecting and reporting data required under the Hospital OQR Program can be accomplished by staff with a median hourly wage of \$38.80 per hour.⁵

(1) Administrative Burden

Administrative burden involves the time and effort associated with completing program and system requirements and managing facility operations (78 FR 75171), and includes duties such as ensuring staffing, identifying and maintaining an active QualityNet Website Security Administrator, and filling out forms and other paperwork.

As previously noted in Section B(3), the Hospital OQR Program utilizes three forms in its administrative activities (1) Validation Review; (2) Extraordinary Circumstances Exception (ECE) Request; and (3) Reconsideration Request. None of these forms are completed on an annual basis; all are on a need-to-use, exception basis and most hospitals will not need to complete any of these forms in any given year. Thus, the burden associated with forms utilized in the Hospital OQR Program is nominal, if any.

The burden associated with submitting an Extraordinary Circumstances Exception (ECE) Request is accounted for in OMB Control Number 0938-1022, and is therefore excluded from this burden estimate. Moreover, consistent with regulations under the Paperwork Reduction Act of 1995, 5 C.F.R. § 1320.4, the burden associated with filing a Reconsideration Request is excluded from this package because this collection occurs during the conduct of an administrative action.

We initially estimated, in the CY 2014 OPPS/ASC final rule with comment period (78 FR 75171), that the burden associated with completing administrative requirements is 42 hours per hospital. Therefore, for all participating hospitals, we estimate a total annual administrative

⁴ For the CY 2021 payment determination, 3,164 subsection (d) hospitals were eligible to submit data under the Hospital OQR Program.

⁵ In the CY 2018 OPPS/ASC final rule with comment period (82 FR 59477), we finalized an hourly wage estimate of \$18.29 per hour, plus 100 percent overhead and fringe benefits. Current information from the Bureau of Labor Statistics (Found at <https://www.bls.gov/ooh/healthcare/medical-records-and-health-information-technicians.htm> on April, 9, 2020) shows that the current median pay for a Medical Records and Health Information Technician is \$19.40/hour. Accordingly, we have updated and calculated cost burden to hospitals using a wage plus benefits estimate of \$38.80 per hour.

burden of 132,888 hours (42 hours per hospital x 3,164 hospitals) and an estimated total financial burden of approximately \$5.156,054 (132,888 hours x \$38.80 per hour).

(2) Chart-Abstraction Burden

For the CY 2023 payment determination, the chart-abstracted measure set for the Hospital OQR Program is comprised of the following four measures: (1) OP-2; (2) OP-3; (4) OP-18; and (5) OP-23.

For chart-abstracted measures where patient-level data is submitted directly to CMS, we previously estimated it would take 2.9 minutes, or 0.049 hours per measure to collect and submit the data for each submitted case (80 FR 70582). Additionally, based on the most recent data from CY 2015 reporting, we estimate that 947 cases⁶ are reported per hospital for chart-abstracted measures (82 FR 59478). We continue to estimate that it will take approximately 46 hours (0.049 hours x 947 cases) to collect and report data for each chart-abstracted measure. Therefore, for all participating hospitals, we estimate an annual chart-abstraction burden of 578,864 hours (46 hours per hospital x 3,164 hospitals x 4 measures) and an estimated financial burden of \$22,459,923 (578,864 x \$38.80 per hour).

(3) Web-Based Measures Burden

There are three web-based measures in the Hospital OQR Program for the CY 2023 payment determination and subsequent years: OP-22, OP-29, and OP-31. We previously estimated, in the CY 2016 OP/ASC final rule with comment period (80 FR 70582), that hospitals spend approximately 10 minutes, or 0.167 hours, per measure to report web-based measures.

Estimated annual web-based burden for all participating hospital would be 1,057 hours (0.167 hours per hospital x 3,164 hospitals x 2 measures) for OP-22 and OP-29. We estimate an annual burden of 106 hours (0.167 hours per hospital x 3,164 hospitals x 1 measure x 20%) for OP-31 which we expect 20% of hospitals to voluntarily report. This results in a total burden of 1,163 hours (1,057 hours + 106 hours) and a total cost of \$45,124 (1,163 hours x \$38.80 per hour).

There are two web-based measures in the Hospital OQR Program measure set that also require some chart-abstraction: OP-29 and OP-31.

For OP-29, we previously estimated that this web-based measure requires 25 minutes, or 0.417 hours, per case per measure to chart-abstract (78 FR 75171),⁷ and that hospitals would abstract 384 cases per year for this measure (78 FR 75171). Therefore, for all participating hospitals, we estimate an annual chart-abstraction burden of 506,645 hours (0.417 hours per hospital, per case x 384 cases per measure x 3,164 hospitals x 1 measure), and an estimated financial burden of \$19,657,826 (506,645 hours x \$38.80 per hour).

⁶ We note that our estimated number of cases decreased from the 1,266 cases estimated for these measures in previous PRA Packages for the CY 2015 and CY 2016 OP/ASC final rules with comment period.

⁷ In the CY 2014 OP/ASC final rule with comment period (78 FR 75171), we estimated the time to chart-abstract a single case as 25 minutes, or 0.417 hours per case, based on chart-abstraction time less the time to submit web-based measures in the aggregate (0.583 hours – 0.166 hours = 0.417 hours per measure).

The reporting of data associated with the OP-31 measure is voluntary.⁸ We previously estimated that this web-based measure would also require 25 minutes, or 0.417 hours, per case to chart-abstract (78 FR 75171), and that hospitals would abstract 384 cases per year for this measure (78 FR 75171). We also previously estimated that approximately 20 percent of hospitals, or 633 hospitals (3,164 hospitals x 0.2), would elect to report this measure on a voluntary basis (79 FR 67014). Therefore, for all participating hospitals, we continue to estimate an annual chart-abstraction burden of 101,361 hours (0.417 hours per hospital, per case x 384 cases per measure x 633 hospitals x 1 measure), and an estimated financial burden of \$3,932,807 (101,361 hours x \$38.80 per hour).

Total estimated, additional burden for the chart-abstraction portion of these two web-based measures would be 608,006 hours (506,645 hours for OP-29 and + 101,361 hours for OP-31).

Therefore, for all participating hospitals, we estimate an annual burden of 609,169 hours (1,163 hours for web-based burden and 506,645 hours for chart-abstraction) and an estimated financial burden of \$23,635,757 (609,169 hours x \$38.80 per hour) for web-based measures for the CY 2023 payment determination.

(4) Claims-Based Measures Burden

Claims-based measures are derived through analysis of administrative claims data and do not require additional effort or burden on hospitals. As a result, the Hospital OQR Program's claims-based measures (OP-8, OP-10, OP-13, OP-32, OP-35, and OP-36) do not influence our burden calculations.

(5) Survey Measures Burden

In the CY 2018 OP/ASC final rule with comment period (82 FR 59433), CMS finalized the delayed implementation of the five OAS CAHPS survey-based measures (OPs-37a-e) until further action. In the CY 2021 OP/ASC proposed rule, we are not proposing any changes to our delayed implementation of the five OAS CAHPS survey-based measures. As hospital outpatient departments are not currently administering the survey under the Hospital OQR Program, these survey-based measures do not influence our total burden calculations.⁹

(6) Validation Burden

The burden associated with the validation procedures is the time and effort necessary to submit supporting medical record documentation for validation. We previously estimated that it would take each of the 500 selected hospitals approximately 12 hours to comply with these data submission requirements (76 FR 74553, 74577). To comply with the requirements, we also

⁸ Hospitals may voluntarily submit data for OP-31 but will not be subject to a payment reduction with respect to this measure for the CY 2020 payment determination or during the voluntary reporting period.

⁹ In addition, we note the information collection requirements associated with measures OPs-37a-e are currently approved under OMB Control Number 0938-1240; for this reason, we do not provide an independent estimate of the burden associated with the OAS CAHPS survey administration for the Hospital OQR Program.

estimated that each hospital would submit up to 48 cases for the affected year for review (76 FR 74553).

Because all selected hospitals must comply with these requirements each year, we continue to estimate a total submission of up to 24,000 charts by the selected hospitals (500 hospitals × 48 cases per hospital) (76 FR 74553). Therefore, for the selected hospitals, we continue to estimate a total annual validation burden, for four quarters of data, of 6,000 hours (500 hospitals x 12 hours per hospital), and a total financial burden of approximately \$232,800 (6,000 hours x \$38.80 per hour).

(7) Total Burden for the CY 2023 Payment Determination

Based on the burden estimates calculated above for the CY 2023 payment determination, for all participating hospitals, we estimate a total annual burden of 1,326,921 hours, and a total financial burden of approximately \$51.5 million. The table below summarizes our calculations.

Table 2. Total Burden for the CY 2023 Payment Determination

	Total Hours	Total Cost*
Administrative Activities	132,888	\$5,156,054
Chart-Abstracted Measures	578,864	\$22,459,923
Web-Based Measures	609,169	\$23,635,757
Claims-Based Measures	N/A	N/A
Survey-Based Measures	N/A	N/A
Validation	6,000	\$232,800
Total	1,326,921	\$ 51,484,534

*Dollar amounts may vary slightly due to rounding

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs being placed on the hospitals. In fact, successful submission will result in a hospital receiving the full annual payment update, while having to expend no capital costs for participation. CMS is providing a data collection tool and method for submission of data to the participants. There are no additional data submission requirements placing additional cost burdens on hospitals.

14. Cost to Federal Government

The cost to the Federal Government for maintaining program activities is comprised of costs associated with Federal staffing, supporting data system architecture, data storage, maintenance and updating of information technology on My QualityNet, providing ongoing technical assistance to ASCs and data vendors, calculation of claims-based measures, measure development and maintenance, the provision of feedback and preview reports, Hospital Compare support, and the collection and validation of the data.

This program requires three FTEs at a GS-13 Step 5 level to operate. GS-13 Step 5 approximate annual salary is \$116,353 plus benefits (30%) for an additional cost of \$349,059 plus \$104,718 or \$453,777 for this and subsequent program years.

Estimated annual costs information technology costs for this program are \$10,500,000 for data collection and infrastructure. Estimated annual costs based on existing contracts for program support, measure development and maintenance, validation, and Hospital Compare associated activities are \$4,000,000.

For the claims-based measures, CMS uses data from the CMS National Claims History system that is collected to document provider reimbursement; no additional data will need to be submitted by hospitals for claims-based measures which eliminates provider burden. However, CMS bears considerable costs in data collection and analyses, measure calculations, measure endorsement activities, and provision of facility-specific feedback reports for four claims-based imaging efficiency measures and three hospital visits following selected surgical procedure measures. Estimated costs to support these claims-based measure activities are \$3,500,000.

The annual cost to the Federal Government is \$18,453,777.

15. Program or Burden Changes

In the CY 2021 OPPI/ASC proposed rule, we are not proposing the removal or addition of any Hospital OQR Program measures for the CY 2023 payment determination and subsequent years. As a result, we do not estimate any change in burden aside from reductions due the reduced number of eligible providers. The burden hours have decreased by 60,198 (1,387,119 hours - 1,326,921).

16. Publication or Burden Changes

The goal of the data collection is to tabulate and publish hospital specific data. CMS will continue to display information on the quality of care provided in the hospital outpatient setting for public viewing as required by TRHCA. Data from this initiative is currently used to populate the *Hospital Compare* website. We anticipate updating this data on at least an annual basis.

17. Expiration Date

CMS will display the expiration date on the collection instruments.

18. Certification Statement

We certify that the Hospital OQR Program complies with 5 C.F.R. § 1320.9.