Supporting Statement – Part A
Quality Measures and Procedures for the Hospital Inpatient Quality Reporting Program for the FY 2024 IPPS Annual Payment Updates (OMB Control No. 0938-1022)
FY 2022 IPPS/LTCH PPS Proposed Rule (RIN 0938-AU44, CMS-1752-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 the 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 *Care Compare* website or its successor website(s).

Hospitals that indicated their intent to participate will be considered active Hospital IQR Program participants until they submit 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 *Care 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 *Care 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 (NHSN) 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 NHSN enrollment process or entering zero denominator information for inapplicable measures for the hospitals that meet the exception requirements.

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

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 APU 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 or eCQM validation results. To submit a formal request, hospitals can utilize the CMS Quality Reporting Validation Educational Review Form. We note that should the results of an educational review not be favorable to a hospital, a hospital may still also request reconsideration of those results using the CMS Hospital IQR Program Validation Review for Reconsideration Request Form. In this year's rule, we are proposing to extend the effects of educational reviews for 4th quarter data such that if an error is identified during the education review process for 4th quarter data, we would use the corrected quarterly score to compute the final confidence interval used for payment determination beginning with validations affecting the FY 2024 payment determination. Previously, CMS was only able to accommodate educational reviews through the 3rd quarter due to operational timelines.

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 Hospital 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 2024 APU determination will be based on Hospital IQR Program data reported and supporting forms submitted by hospitals on chart-abstracted measures, patient surveys, and eCQMs for calendar year (CY) 2022 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 2022 IPPS/Long-Term Care Hospital (LTCH) PPS proposed rule, we are adding five new measures and removing five existing measures. Proposed changes are discussed below.

a. Proposed Measure Adoptions in the FY 2022 IPPS/LTCH PPS Proposed Rule Which Affect the Burden for the Hospital IQR Program

In the FY 2022 IPPS/LTCH PPS proposed rule, we are adding two new measures which will increase burden for the Hospital IQR Program.

We are proposing to adopt the Maternal Morbidity Structural Measure beginning with a shortened reporting period from October 1 through December 31, 2021 (affecting the FY 2023 payment determination), followed by annual reporting periods for subsequent years.

We are also proposing to adopt the Hybrid Hospital-Wide All-Risk Standardized Mortality measure with Claims and Electronic Health Record Data (Hybrid HWM measure) beginning with a one-year voluntary reporting period (July 1, 2022 through June 30, 2023), followed by mandatory reporting beginning with the July 1, 2023 through June 30, 2024 reporting period/FY 2026 payment determination.

Adopting the two proposed measures will increase our collection of information burden estimates, as is discussed in more detail below.

b. Proposed Updates in the FY 2022 IPPS/LTCH PPS Proposed Rule Which Do Not Affect the Burden for the Hospital IQR Program

In the FY 2022 IPPS/LTCH PPS proposed rule, there are a number of proposals which do not affect our information collection burden estimates, including: (1) Adopting the Hospital Harm—Severe Hyperglycemia electronic clinical quality measure (eCQM) beginning with the CY 2023 reporting period/FY 2025 payment determination; (2) adopting the Hospital Harm—Severe

Hypoglycemia eCQM beginning with the CY 2023 reporting period/FY 2025 payment determination; (3) removing the Death Rate among Surgical Inpatients with Serious Treatable Complications (CMS PSI-04) claims-based measure beginning with the FY 2023 payment determination; (4) removing the Admit Decision Time to ED Departure Time for Admitted Patients (ED-2) eCQM beginning with the CY 2024 reporting period/FY 2026 payment determination; (5) removing the Exclusive Breast Milk Feeding (PC-05) eCQM beginning with the CY 2024 reporting period/FY 2026 payment determination; (6) removing the Anticoagulation Therapy for Atrial Fibrillation/Flutter (STK-03) eCQM beginning with the CY 2024 reporting period/FY 2026 payment determination; (7) removing the Discharged on Statin Medication (STK-06) eCQM beginning with the CY 2024 reporting period/FY 2026 payment determination; (8) revising the Program's regulations at 42 CFR 412.140(a)(2) by replacing the term "QualityNet Administrator" with the term "QualityNet security official" and 42 CFR 412.140(e)(2)(iii) by replacing the term "QualityNet system administrator" with the term "QualityNet security official"; (9) revising the Program's regulations at 42 CFR 412.140(a)(1) and 42 CFR 412.140(c)(2)(i) to remove references to "QualityNet.org" and replacing it with "QualityNet website"; (10) requiring the use of the 2015 Edition Cures Update for certification criteria beginning with the CY 2023 reporting period/FY 2025 payment determination and for subsequent years for both eCQMs and hybrid measures; and (11) extending the effects of educational reviews for 4th quarter data such that if an error is identified during the education review process for 4th quarter data, we would use the corrected quarterly score to compute the final confidence interval used for payment determination beginning with validations affecting the FY 2024 payment determination.

Also, in the FY 2022 IPPS/LTCH PPS proposed rule, we are proposing to adopt a COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure beginning with a shortened reporting period from October 1 to December 31, 2021, affecting the CY 2021 reporting period/FY 2023 payment determination followed by annual reporting for the FY 2024 payment determination and for subsequent years. Currently the CDC does not estimate burden for COVID-19 vaccination reporting under either the CDC PRA OMB control number 0920-1317 or 0920-0666 because the agency has been granted a waiver under Section 321 of the National Childhood Vaccine Injury Act (NCVIA). When the waiver expires, we will work with CDC to ensure that this burden is accounted for under their PRA package.

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 is 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 *Care 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 *Care 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 electronic health records (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 NHSN), as well as to increase the utility of the data provided by the hospitals.

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 Medicare 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 approximately 950 participating IPPS small hospitals in the FY 2022 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.

Measure Type	*Frequency of Data Submission*
Chart-abstracted clinical process of care	Quarterly
Online reporting of structural measures	Annually
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 2022 IPPS/LTCH PPS proposed rule (RIN 0938-AU44, CMS-1752-P) published on May 10, 2021 (86 FR 25070). CMS did not receive comments specific to the collection of information requirements.

CMS is supported in this initiative by The Joint Commission, National Quality Forum (NQF), Measure Applications Partnership (MAP), Centers for Disease Control and Prevention (CDC), and Agency for Healthcare Research and Quality (AHRQ). 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.

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 1,572,443 hours at a cost of approximately $64.5 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 2023 payment determination. Our burden estimates exclude burden associated with the NHSN 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 finalizing any changes to the currently approved burden estimates for chart-abstracted measures (sepsis and perinatal care), the 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 2023 through FY 2027 payment determination years. Changes to currently approved burden estimates due to proposed policies in the FY 2022 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 2023 Payment Determination

Measure Set	***Estimated time per record (minutes) - FY 2023 payment determination***	***Number reporting quarters per year - FY 2023 payment determination***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Calculation for FY 2023 payment determination***
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 eCQMs						
IPPS Hospitals (3,300)						
Reporting 4 eCQMs	40	2	3,300	1	1.33	4,400
Non-IPPS Hospitals (1,100)						
Reporting 4 eCQMs	40	2	1,100	1	1.33	1,467
eCQM Subtotal (IPPS and Non-IPPS)					**-**	**5,867**
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
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					**19.25**	**38,500**
Total Burden Hours						**1,572,443**
Total Burden @ Medical Records and Health Information Technician labor rate ($41.00/hr)						**$64,470,149**

b. Updated Hourly Wage Rate

In the FY 2021 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 $19.40 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 $20.50 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 ($20.50 × 2 = $41.00) 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 Dosimetrists, Medical Records Specialists, and Health Technologists and Technicians, All Other. Available at: https://www.bls.gov/oes/2019/may/oes292098.htm. Accessed 9 April 2021.

availability of this more recent wage data, we have updated the wage rate used in these calculations in the FY 2022 IPPS/LTCH PPS proposed rule and this corresponding PRA package to $41.00.

c. Chart-Abstracted Measure Reporting and Submission Requirements for the CY 2022 Reporting Period/FY 2024 Payment Determination, the CY 2023 Reporting Period/FY 2025 Payment Determination, and the CY 2024 Reporting Period/FY 2026 Payment Determination and Subsequent Years

We are not proposing any changes to the reporting or submission requirements for chart-abstracted measures in the FY 2022 IPPS/LTCH PPS proposed rule. As shown in Table 1, we continue to estimate the information collection burden associated with the reporting of chart-abstracted measures to be 60 minutes or 1 hour per record for the sepsis measure and 10 minutes or 0.167 hours per record for the perinatal care measure. We continue to assume that each IPPS hospital will report 100 and 76 records quarterly for the sepsis measure and perinatal care measure, respectively. We estimate a total annual burden of 400 hours (1 hour/record x 100 records x 4 quarters) per IPPS hospital for the sepsis measure and 51 hours (0.167 hours/record x 76 records x 4 quarters) per IPPS hospital for the perinatal care measure. We estimate an annual burden of 1,487,200 hours (451 hours/hospital x 3,300 IPPS hospitals) at a cost of $60,975,200 (1,487,200 hours x $41.00/hour).

d. eCQM Reporting and Submission Requirements for the CY 2022 Reporting Period/FY 2024 Payment Determination, the CY 2023 Reporting Period/FY 2025 Payment Determination, and the CY 2024 Reporting Period/FY 2026 Payment Determination and Subsequent Years

In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58974 through 58975), we finalized 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, 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—Concurrent Prescribing 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 continue to estimate the information collection burden associated with the eCQM reporting and submission requirements to be 40 minutes or 0.67 hours per hospital per quarter (10 minutes x 4 eCQMs x 1 quarter = 40 minutes/0.67 hours). We estimate a total burden of 2,200 hours across all IPPS hospitals (0.67 hours × 3,300 IPPS hospitals) for each quarter of eCQM data. As shown in Table 2, using the updated wage estimate described above, we estimate this to represent a total cost of $90,200 ($41.00 hourly wage × 2,200 annual hours) across all IPPS hospitals per each quarter of data. For the CY 2022 reporting period/FY 2024 payment determination, we estimate a total burden of 6,600 burden hours at a cost of $270,600 (6,600

hours x $41.00/hour) for reporting three quarters of eCQM data. For the CY 2023 reporting period/FY 2025 payment determination and subsequent years, we estimate a total of 8,800 hours at a cost of $360,800 (8,800 hours x $41.00/hr) for reporting four quarters of eCQM data.

As previously stated, in the FY 2022 IPPS/LTCH PPS proposed rule, we are proposing to adopt two eCQMs beginning with the CY 2023 reporting period/FY 2025 payment determination: (1) Hospital Harm—Severe Hyperglycemia eCQM; and (2) Hospital Harm—Severe Hypoglycemia eCQM. We are also proposing to adopt the COVID-19 Vaccination Coverage for HCP measure beginning with a shortened reporting period from October 1 to December 31, 2021, affecting the CY 2021 reporting period/FY 2023 payment determination followed by annual reporting for the FY 2024 payment determination and for subsequent years. As mentioned above, the CDC currently does not estimate burden for COVID-19 vaccination reporting under either the CDC PRA OMB control number 0920-1317 or 0920-0666 because the agency has been granted a waiver under Section 321 of the National Childhood Vaccine Injury Act (NCVIA). We are also proposing to remove four eCQMs beginning with the CY 2024 reporting period/FY 2026 payment determination: (1) Admit Decision Time to ED Departure Time for Admitted Patients (ED-2); (2) Exclusive Breast Milk Feeding (PC-05); (3) Anticoagulation Therapy for Atrial Fibrillation/Flutter (STK-03); and (4) Discharged on Statin Medication (STK-06) eCQMs. We do not believe that our proposals to add two eCQMs and remove four eCQMS from the eCQM measure set will affect the information collection burden of submitting eCQMs under the Hospital IQR Program. Current Hospital IQR Program policy requires hospitals to report a total of four eCQMs from the eCQM measure set (three self-selected eCQMs and the Safe Use of Opioids—Concurrent Prescribing eCQM) for the CY 2022 reporting period/FY 2024 payment determination and subsequent years (85 FR 58437). In other words, while these proposals would result in new eCQMs being added to and some eCQMs being removed from the eCQM measure set, hospitals will not be required to report more than a total of four eCQMs as is currently required (84 FR 42603).

Table 2. Estimated Burden for the eCQM Reporting and Submission Requirements for the FY 2024 through FY 2027 Payment Determination Years

eCQM Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 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 ($41.00/hr)						**$360,800**

FY 2025 through FY 2027 Payment Determination Years						
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 ($41.00/hr)						**$481,067**

e. Maternal Morbidity Structural Measure Reporting and Submission Requirements Beginning with the CY 2021 Reporting Period/FY 2023 Payment Determination

In the FY 2022 IPPS/LTCH PPS proposed rule, we are proposing to adopt the Maternal Morbidity Structural Measure beginning with the CY 2021 reporting period/FY 2023 payment determination. The shortened data reporting period for the Maternal Morbidity Structural Measure would run from October 1 through December 31, 2021, followed by annual reporting periods for subsequent years. Reporting on the Maternal Morbidity Structural Measure would involve each hospital responding to a single question using a web-based tool available via the QualityNet Secure Portal (also referred to as the Hospital Quality Reporting (HQR) System) with one of the following response options: (A) "Yes"; (B) "No"; or (C) "N/A (our hospital does not provide inpatient labor/delivery care)."

If the proposal is finalized, hospitals would be required to submit the response on an annual basis during the submission period. We estimate the information collection burden associated with this proposed structural measure to be no more than five minutes per hospital per year, as it involves responding to a single question one time per year for a given reporting period. As shown in Table 3, using the estimate of five minutes (or 0.083 hours) per hospital per year, and the updated wage estimate as described previously, we estimate that this policy will result in a total annual burden increase of 275 hours across all IPPS hospitals (0.083 hours × 3,300 IPPS hospitals) at a cost of $11,275 (275 hours × $41.00/hour).

Table 3. Estimated Burden for the Maternal Morbidity Structural Measure for the FY 2023 through FY 2027 Payment Determination Years

Maternal Morbidity Structural Measure	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 2023 through FY 2027 Payment Determination Years						
IPPS Hospitals	5	1	3,300	1	0.08	275
Non-IPPS Hospitals	5	1	1,100	1	0.08	91.7
Total Burden Hours						**366.7**
Total Burden @ Medical Records and Health Information Technician labor rate ($41.00/hr)						**$15,033**

f. Hybrid Hospital Wide Readmission Measure (Hybrid HWR measure) and Proposed Hybrid Hospital-Wide Mortality Measure (Hybrid HWM measure) with Claims and Electronic Health Record Data Beginning with the CY 2022 Reporting Period/FY 2024 Payment Determination

In the FY 2020 IPPS/LTCH PPS final rule, we finalized the adoption of the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data (Hybrid HWR measure) (84 FR 42505 through 42508). We continue to estimate the information collection burden associated with this measure will be 10 minutes per quarter for each hospital. The total annual burden estimate beginning with the CY 2022 reporting period/FY 2024 payment determination is 0.67 hours per hospital (10 minutes/quarter x 4 quarters) at a cost of $27.33 (0.67 hours x $41.00/hour) for each hospital. The total annual burden for all 3,300 IPPS hospitals is estimated to be 2,200 hours (0.67 hours/hospital x 3,300 hospitals) at a cost of $90,200 (2,200 hours x $41.00/hour).

In the FY 2022 IPPS/LTCH PPS proposed rule, we are proposing to establish a voluntary reporting period for the Hybrid Hospital-Wide Mortality Measure with Claims and Electronic Health Record Data (NQF #3502) (Hybrid HWM measure). The voluntary reporting period would run from July 1, 2022 through June 30, 2023. We also are proposing to require reporting of the Hybrid HWM measure beginning with the reporting period which would run from July 1, 2023 through June 30, 2024 affecting the FY 2026 payment determination and for subsequent years.

Similar to the Hybrid HWR measure, the Hybrid HWM measure uses both claims-based data and EHR data, specifically, a set of core clinical data elements consisting of vital signs and laboratory test information and patient linking variables collected from hospitals' EHR systems. We do not expect any additional burden to hospitals to report the claims-based portion of this measure because these data are already reported to the Medicare program for payment purposes. However, we do expect that hospitals would experience burden in reporting the EHR data. To report the EHR data, hospitals would use the same submission process as finalized in the FY 2020 IPPS/LTCH PPS final rule for reporting the Hybrid HWR measure (84 FR 42505 through 42508). We expect the burden associated with reporting of the Hybrid HWM measure to be similar to our estimates for reporting the Hybrid HWR measure, that is, 10 minutes per measure, per quarter. Therefore, using the estimate of 10 minutes per measure per quarter (10 minutes × 1 measure × 4 quarters = 40 minutes), we estimate that our proposal will result in a burden increase of 40 minutes (0.67 hours) per hospital per year.

As shown in Table 4, beginning with the voluntary reporting period, which runs from July 1, 2022 through June 30, 2023, we estimate an annual burden increase of 2,200 hours across participating IPPS hospitals (0.67 hours × 3,300 IPPS hospitals). Using the updated wage estimate, as previously described, we estimate this to represent a cost increase of $90,200 across IPPS hospitals ($41 × 2,200 hours). If our proposal to adopt the Hybrid HWM measure is finalized, we will encourage all hospitals to submit data for the Hybrid HWM measure during the voluntary reporting period. For that reason, our burden estimates are based on the assumption that all hospitals would participate during the voluntary reporting period (July 1, 2022 through

June 30, 2023) as well as for the required reporting period (July 1, 2023 through June 30, 2024) and subsequent reporting periods for which public reporting would begin. Due to the voluntary reporting period beginning in the third quarter of the CY 2022 reporting period/FY 2024 payment determination, the total burden of for the first year assumes only two quarters of reporting and is estimated to be 1,100 hours (0.33 hours x 3,300 IPPS hospitals) at a cost of $45,100 ($41.00/hour x 1,100 hours). Beginning with the CY 2023 reporting period/FY 2025 payment determination, the total burden estimate will be based on four quarters of reporting.

Table 4. Estimated Burden for the Hybrid HWM and HWR Measures Reporting and Submission Requirements for the FY 2024 through FY 2027 Payment Determination Years

Hybrid Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 2024 Payment Determination						
Hybrid HWR Measure (IPPS Hospitals)	10	4	3,300	1	0.67	2,200
Hybrid HWR Measure (Non-IPPS Hospitals)	10	4	1,100	1	0.67	733.3
Total HWR Measure Burden Hours						**2,933.3**
Hybrid HWM Measure (IPPS Hospitals)	10	2	3,300	1	0.33	1,100
Hybrid HWM Measure (Non-IPPS Hospitals)	10	2	1,100	1	0.33	366.7
Total HWM Measure Burden Hours						**1,466.7**
Total Burden @ Medical Records and Health Information Technician labor rate ($41.00/hr)						**$180,400**
FY 2025 through FY 2027 Payment Determination Years						
Hybrid HWR Measure (IPPS Hospitals)	10	4	3,300	1	0.67	2,200
Hybrid HWR Measure (Non-IPPS Hospitals)	10	4	1,100	1	0.67	733.3
Total HWR Measure Burden Hours						**2,933.3**
Hybrid HWM Measure (IPPS Hospitals)	10	4	3,300	1	0.67	2,200
Hybrid HWM Measure (Non-IPPS Hospitals)	10	4	1,100	1	0.67	733.3

Total HWM Measure Burden Hours	**2,933.3**
Total Burden @ Medical Records and Health Information Technician labor rate ($41.00/hr)	**$240,533**

g. Validation of Hospital IQR Program Measure Data, Population and Sampling for Ongoing Measure Sets, and Reviewing Reports for Claims-Based Measure Sets

In the FY 2022 IPPS/LTCH PPS proposed rule, we are proposing to extend the educational review policy to use the corrected quarterly score identified through an educational review to compute the final confidence interval for all 4 quarters of validation for chart-abstracted measures. We expect that our proposal will not yield a change in burden as it does not affect the requirements for data submission for hospitals, but only modifies how CMS uses the data already being submitted.

We continue to estimate the information collection burden associated with eCQM validation beginning with the CY 2022 reporting period/FY 2024 payment determination to be 10 minutes per record for the pool of 400 hospitals selected. As shown in Table 6, 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 $43,733 ($41.00/hour × 1,067 annual hours). 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 $65,600 ($41.00/hour × 1,600 annual hours). 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 $87,467 ($41.00/hour × 2,133 annual hours).

As shown in Table 1, we continue to estimate the information collection burden associated with population and sampling of ongoing measure sets to be 15 minutes per record per quarter and assume each hospital will report four records for four quarters each year. The total annual burden estimate per hospital is 4 hours (15 minutes/record/quarter x 4 records x 4 quarters) at a cost of $164 ($41.00/hour x 4 hours). For all 4,400 IPPS and non-IPPS hospitals, we estimate a total annual burden of 17,600 hours (4 hours x 4,400 hospitals) at a cost of $721,600 ($41.00/hour x 17,600 hours).

Also as shown in Table 1, we continue to estimate the information collection burden associated with reviewing reports for claims-based measure sets to be 60 minutes per record per quarter and assume each hospital will report one record for four quarters each year. The total annual burden estimate per hospital is 4 hours (60 minutes/quarter x 4 quarters) at a cost of $164 ($41.00/hour x 4 hours). For all 4,400 IPPS and non-IPPS hospitals, we estimate a total annual burden of 17,600 hours (4 hours x 4,400 hospitals) at a cost of $721,600 ($41.00/hour x 17,600 hours).

h. Additional Information on Burden Estimates

Time estimates for activities other than abstracting charts, including completion of the forms listed below, 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.j. 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 2018, 89 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 89 ECE requests was 1,335 minutes (or 22.25 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.

As shown in Table 1, we estimate the information collection burden per hospital associated with completing all other forms used in the data collection process to be 15 minutes (0.25 hours) per year at a cost of $10.25 ($41.00/hour x 0.25 hours). For all 4,400 IPPS and non-IPPS hospitals, we estimate a total annual burden of 1,100 hours (0.25 hours x 4,400 hospitals) at a cost of $45,100 ($41.00/hour x 1,100 hours).

i. Burden Estimate Summary

As shown in Tables 5 and 6, in summary, under OMB control number 0938-1022, we estimate a total information collection burden increase for 3,300 IPPS hospitals of 2,475 hours (275 hours + 2,200 hours) associated with our finalized policies and updated burden estimates described above and a total cost increase related to this information collection of approximately $101,475 ($41.00/hour × 2,475 hours) (which also reflects use of an updated hourly wage rate as previously discussed), across a four-year period from the CY 2022 reporting period/FY 2024 payment determination through the CY 2025 reporting period/FY 2027 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 2027 payment determination reflects the cumulative burden changes).

Table 5. Summary of Annual Burden Hour Estimates for the FY 2023 through FY 2027 Payment Determination Years

	ANNUAL BURDEN HOURS									
Information Collection	**FY2023**	**Difference from Currently Approved**	**FY2024**	**Difference from Currently Approved**	**FY2025**	**Difference from Currently Approved**	**FY2026**	**Difference from Currently Approved**	**FY2027**	**Difference from Currently Approved**
Chart Abstraction										
IPPS	1,487,200	0	1,487,200	0	1,487,200	0	1,487,200	0	1,487,200	**0**
Non-IPPS	40,876	0	40,876	0	40,876	0	40,876	0	40,876	**0**
Hybrid Measures*										
IPPS										
Hybrid HWR	0	0	2,200	-11**	2,200	0	2,200	0	2,200	**0**
Hybrid HWM	0	0	1,100	+1,100	2,200	+2,200	2,200	+2,200	2,200	**+2,200**
Non-IPPS										
Hybrid HWR	0	0	733	-4**	733	0	733	0	733	**0**
Hybrid HWM	0	0	367	+367	733	+733	733	+733	733	**+733**
Maternal Morbidity Structural Measure										
IPPS	275	+275	275	+275	275	+275	275	+275	275	**+275**
Non-IPPS	92	+92	92	+92	92	+92	92	+92	92	**+92**
Reporting eCQMs										
IPPS	4,400	0	6,600	0	8,800	0	8,800	0	8,800	**0**
Non-IPPS	1,467	0	2,200	0	2,933	0	2,933	0	2,933	**0**
Population and sampling for the ongoing measure sets	17,600	0	17,600	0	17,600	0	17,600	00	17,600	**0**
Review reports for claims-based measure sets	17,600	0	17,600	0	17,600	0	17,600	0	17,600	**0**
eCQM Validation	2,200	0	1,067	0	1,600	0	2,133	0	2,133	**0**
All other forms used in the data collection process	1,100	0	1,100	0	1,100	0	1,100	0	1,100	**0**
TOTAL	**1,572,810**	**+367**	**1,579,010**	**+1,819**	**1,583,942**	**+3,300**	**1,584,475**	**+3,300**	**1,584,475**	**+3,300**

* Burden associated with the Hybrid Hospital-Wide All-Cause Readmission Measure was previously finalized in the FY 2020 IPPS/LTCH PPS final rule.
** Due to correction of rounding in the calculation of the time for reporting of this measure, we have updated the value in this year's PRA to the more accurate 2,200 and 733 hours instead of the 2,211 and 737 hours (respectively) used in last year's PRA package.

Table 6. Summary of Annual Burden Cost Estimates for the FY 2023 through FY 2027 Payment Determination Years*

	ANNUAL BURDEN COST									
Information Collection	**FY2023**	**Difference from Currently Approved**	**FY2024**	**Difference from Currently Approved**	**FY2025**	**Difference from Currently Approved**	**FY2026**	**Difference from Currently Approved**	**FY2027**	**Difference from Currently Approved**
Chart Abstraction										
IPPS	$60,975,200	0	$60,975,200	0	$60,975,200	0	$60,975,200	0	$60,975,200	0
Non-IPPS	$1,675,916	0	$1,675,916	0	$1,675,916	0	$1,675,916	0	$1,675,916	0
Hybrid Measures										
IPPS										
Hybrid HWR	0	0	$90,200	-$451	$90,200	0	$90,200	0	$90,200	0
Hybrid HWM	0	0	$45,100	+$45,100	$90,200	+$90,200	$90,200	+$90,200	$90,200	+$90,200
Non-IPPS										
Hybrid HWR	0	0	$30,067	-$164	$30,067	0	$30,067	0	$30,067	0
Hybrid HWM	0	0	$15,033	+$15,033	$30,067	+$30,067	$30,067	+$30,067	$30,067	+$30,067
Maternal Morbidity Structural Measure										
IPPS	$11,275	+$11,275	$11,275	+$11,275	$11,275	+$11,275	$11,275	+$11,275	$11,275	+$11,275
Non-IPPS	$3,758	+$3,758	$3,758	+$3,758	$3,758	+$3,758	$3,758	+$3,758	$3,758	+$3,758
Reporting eCQMs										
IPPS	$180,400	0	$270,600	0	$360,800	0	$360,800	0	$360,800	0
Non-IPPS	$60,133	0	$90,200	0	$120,267	0	$120,267	0	$120,267	0
Population and sampling for the ongoing measure sets	$721,600	0	$721,600	0	$721,600	0	$721,600	0	$721,600	0
Review reports for claims-based measure sets	$721,600	0	$721,600	0	$721,600	0	$721,600	0	$721,600	0
eCQM Validation	$90,200	0	$43,733	0	$65,600	0	$87,467	0	$87,467	0

All other forms used in the data collection process	$45,100	0	$45,100	0	$45,100	0	$45,100	0	$45,100	0
TOTAL	**$64,485,182**	**+$15,033**	**$64,739,382**	**+$74,551**	**$64,941,650**	**+$135,300**	**$64,963,517**	**+$135,300**	**$64,963,517**	**+$135,300**

* Cost estimates are based on updated wage rate of $41.00. Differences from currently approved burden account for updating estimates of currently approved hours to the new wage rate.

j. Information Collection Instruments/Instructions

- The Hospital Inpatient Quality Reporting Notice of Participation is being resubmitted for updates made to the instructions to reflect changes to the NOP application process in the new Hospital Quality Reporting (HQR) System.

- The Hospital Quality Reporting Data Accuracy and Completeness Acknowledgement form is being resubmitted to reflect updates to references to the QualityNet Secure Portal to Hospital Quality Reporting Secure Portal.

- The Hospital Compare Request Form for Withholding/Footnoting Data for Public Reporting is being resubmitted to update the references to Hospital Compare to Care Compare. Additionally, the Admit Decision Time to ED Departure Time for Admitted Patients – Reporting Measure (ED-2b) measure was removed from Table 1 and Medication Continuation following Discharge from an Inpatient Psychiatric Facility measure (MedCont)was added to Table 2.

- The CMS IPPS Quality Reporting Programs Measure Exception Form for PC and HAI Data Submission is being resubmitted to update the references to the QualityNet Secure Portal to Hospital Quality Reporting Secure Portal and Secure File Transfer to Managed File Transfer.

- The CMS Quality Reporting Program APU Reconsideration Request Form is being resubmitted to update references to the QualityNet Secure Portal to Hospital Quality Reporting Secure Portal and Secure File Transfer to Managed File Transfer.

- The CMS Hospital IQR Program Validation Review for Reconsideration Request Form is being resubmitted to update the references to the QualityNet Secure Portal to Hospital Quality Reporting Secure Portal and Secure File Transfer to Managed File Transfer.

- The CMS Quality Program Extraordinary Circumstances Exceptions (ECE) Request Form is being resubmitted to update the references to the QualityNet Secure Portal to Hospital Quality Reporting Secure Portal. Additional updates include: (1) combining the list of programs into one table; (2) restructuring the order of the form to put contact information first; and (3) updating the submission instruction section, including added language to ask for specific reasons for submitting an ECE request.

- The Hospital Value-Based Purchasing (VBP) Program Review and Corrections Request Form, Appeal Request Form, and Independent CMS Review Request Form are being resubmitted to update the references to the QualityNet Secure Portal to Hospital Quality Reporting Secure Portal and Secure File Transfer to Managed File Transfer.

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

- CMS Quality Reporting Validation Educational Review Form

13. Capital Costs (Maintenance of Capital Costs)

In the FY 2022 IPPS/LTCH PPS proposed rule, we are proposing an update to certification requirements requiring the use of the 2015 Edition Cures Update for eCQMs and hybrid measures beginning with the FY 2025 payment determination. Although this proposal will require some investment in systems updates, the Medicare Promoting Interoperability Program (previously known as the Medicare and Medicaid EHR Incentive Programs) previously finalized a requirement that hospitals use the 2015 Edition Cures Update for eCQMs (85 FR 84818 through 84825). Because all hospitals participating in the Hospital IQR Program are subsection (d) hospitals that also participate in the Medicare Promoting Interoperability Program, we do not anticipate any additional costs as a result of this proposal. This is because the burden and costs involved in updating to the 2015 Edition Cures Update is the same regardless of whether the technology is used for eCQMs or hybrid measures. Hybrid measure data is derived from both claims and clinical EHR data, via submission of Quality Reporting Document Architecture (QRDA) I files, and we already collect and utilize claims data and QRDA I file data for other measures in the Hospital IQR Program measure set. In other words, what hospitals need to do is not measure dependent. Therefore, we believe that the Medicare Promoting Interoperability Program has already addressed the additional costs unrelated to data submission through their previously finalized requirements.

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 $103,690 per staff member to operate for an additional cost of $311,070.

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 2021 reporting period/FY 2023 payment determination of 1,572,443 hours at a total cost of approximately $64.5 million (accounting for updated wage rates) as a result of policies finalized in the FY 2021 IPPS/LTCH PPS final rule. The updated wage rate from $38.80/hour to $41.00/hour results in a total increase of approximately $3.5 million.

The proposal in the FY 2022 IPPS/LTCH PPS proposed rule to adopt the Maternal Morbidity Structural Measure for the FY 2023 payment determination results in an increase of 367 hours and $15,033 for the CY 2021 reporting period/FY 2023 payment determination. The proposal to adopt the Hybrid HWM measure beginning in the CY 2022 reporting period/FY 2024 payment determination results in an increase of 2,933 hours and $120,267. The aggregate increase due to these proposals is 3,300 hours and $135,300 as shown in Tables 5 and 6.

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 *Care Compare* website, https://www.medicare.gov/care-compare/, or its successor website(s). Data are presented on *Care 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 *Care Compare* in performance categories of Better, No Different, or Worse than the National Rate. More detailed measure data, including the data used for *Care Compare*, are also available to the public as downloadable files at https://data.medicare.gov. Hospital quality data on *Care 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 the *QualityNet* website (https://qualitynet.cms.gov). We will also display the approved expiration date prominently on the *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.