Supporting Statement Part A
Implementation of Medicare Programs; - Promoting Interoperability Programs (Stage 3) (CMS-10552)

Background

The Centers for Medicare & Medicaid Services (CMS) is requesting approval to collect information from eligible hospitals and critical access hospitals (CAHs). We are finalizing changes to this program as discussed in the FY 2023 Inpatient Prospective Payment System (IPPS)/Long-term Care Hospital Prospective Payment System (LTCH PPS) Final Rule.

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

The HITECH Act created incentive programs for EPs and eligible hospitals, including CAHs, in the Medicare Fee-for-Service (FFS), MA, and Medicaid programs that successfully demonstrate meaningful use of CEHRT. In their first payment year, Medicaid EPs and eligible hospitals could adopt, implement, or upgrade to certified EHR technology. It also allowed for negative payment adjustments in the Medicare FFS and MA programs starting in 2015 for EPs, eligible hospitals, and CAHs participating in Medicare that are not meaningful users of CEHRT. The Medicaid Promoting Interoperability Program did not authorize negative payment adjustments, but its participants were eligible for incentive payments.

In CY 2017, we began collecting data from eligible hospitals and CAHs to determine the application of the Medicare payment adjustments. At this time, Medicare eligible professionals no longer reported to the EHR Incentive Program, as they began reporting under the Merit-based Incentive Payment System (MIPS). This information collected was also used to make incentive payments to eligible hospitals in Puerto Rico. In subsequent years, we have we focused on reducing burden on eligible hospitals and CAHs by decreasing the amount of time needed to report on measures. We also finalized an optional opioid measure and one new care coordination measure to help address the opioid epidemic and improve interoperability while also implementing changes designed to incentivize the advanced use of CEHRT to support health information exchange, interoperability, advanced quality measurement, and maximizing clinical effectiveness and efficiencies.

In the FY 2023 IPPS/LTCH PPS final rule, we are finalizing the following changes for eligible hospitals and CAHs that attest to CMS under the Medicare Promoting Interoperability Program that we expect to affect our collection of information burden

estimates: (1) requiring the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure beginning in the CY 2023 EHR reporting period while maintaining its associated points at 10 points with three exclusions; (2) adopting a new Antimicrobial Use and Resistance (AUR) Surveillance measure that would be required for eligible hospitals and CAHs under the Medicare Promoting Interoperability Program's Public Health and Clinical Data Exchange Objective with associated exclusions beginning with the CY 2024 EHR reporting period; and (3) requiring eligible hospitals and CAHs to submit their level of active engagement in addition to submitting responses for the Public Health and Clinical Data Exchange Objective required measures and the optional measures beginning with the CY 2023 EHR reporting period. We are also modifying our eCQM reporting and submission requirements whereby we are increasing the total number of eCQMs to be reported from four to six eCQMs beginning with the CY 2024 reporting period.

A. Justification

1. Need and Legal Basis

This information collection serves to implement the HITECH Act. We have developed objectives and measures to collect data and have the healthcare providers attest that they have met the requirements of the Medicare Promoting Interoperability Program. Eligible hospitals and CAHs must successfully demonstrate meaningful use under the Medicare Promoting Interoperability Program to avoid a downward payment adjustment.

According to the HITECH Act of 2009, we must have a means to collect data from participants, and we have used attestation as that means. We have developed objectives and measures as the tools to collect data, in addition to having the healthcare providers attest that they have met the requirements of the Medicare Promoting Interoperability Program.

2. Information Users

The collection of information under this data collection is used to validate compliance with the requirements for being a successful meaningful user under the Medicare Promoting Interoperability Program. Participants attest to the required objectives and measures to meet the required threshold for being considered a Meaningful User. They must also electronically submit clinical quality measure data (eCQMs). If it is determined that the participant is a not a Meaningful User, they would be subject to a downward payment adjustment. The collection of information burden analysis in the FY 2023 IPPS/LTCH PPS final rule focuses on eligible hospitals and CAHs that attest to the objectives and measures, and report eCQMs, under the Medicare Promoting Interoperability Program.

We use the information collected from measure submissions to gain a better understanding of how eligible hospitals and CAHs are utilizing CEHRT and its functionality. We use the information collected from clinical quality measure data to

determine its impact on care delivery for Medicare beneficiaries. Our goal is to continue to advance the meaningful use of health information technology with our priority to continue promoting interoperability through health information exchange among various health systems' EHRs.

3. Improved Information Technology

The attestation is completed on an annual basis via an online submission form (508 compliant). Outside of this online attestation, there are no physical nor additional forms used. Developers and CMS commonly refer to this program-specific format as the Attestation Screens, which are only open for completion by eligible hospitals and CAHs between January and March (exact dates may vary due to calendar).

4. Duplication of Similar Information

There is no duplication of effort on information associated with this collection.

5. Small Businesses

The only small businesses affected by this effort will be those small eligible hospitals and CAHs (we define a "small hospital" as one with 1-99 inpatient beds) that participate in the Medicare Promoting Interoperability Program. Ninety-nine percent of all hospitals have adopted EHRs. We have minimized the impact on these entities by allowing all healthcare providers to apply for a significant hardship exception if they meet certain hardship criteria. This will help to minimize the impact on healthcare providers that are unable to meet the program requirements. Eligible hospitals and CAHs would need to submit a new application for subsequent years and no eligible hospital or CAH can be granted an exception for more than five years (Section 1886(b)(3)(B)(ix)(II) of the Social Security Act). Please note each hardship is reviewed on a case by case basis.

6. Less Frequent Collection

We have designed the collection of information under the Medicare Promoting Interoperability Program to be the minimum necessary for eligible hospitals and CAHs to demonstrate the meaningful use of CEHRT. To implement the meaningful use provisions of the HITECH Act and receive incentives and/or avoid downward payment adjustments under the Medicare Promoting Interoperability Program, eligible hospitals and CAHs are required to attest to the identification of the CEHRT used, satisfaction of the applicable objectives and measures, and electronic reporting of quality measures annually. Less frequent information collection would impede efforts to establish compliance with the HITECH Act.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

A 60-day Federal Register notice of the FY 2023 IPPS/LTCH PPS proposed rule (RIN 0938-AU84, CMS-1771-P) was published on May 10, 2022 (87 FR 28108). We did not receive comments regarding the burden estimates included in this PRA package. The FY 2023 IPPS/LTCH PPS final rule (RIN 0938-AU84, CMS-1771-F), which published on August 10, 2022 (87 FR 48780).

9. Payment/Gift to Respondent

No gifts will be given to respondents for participation. The program has historically utilized incentive payments to Medicare and Medicaid providers who successfully demonstrated meaningful use, however, these positive incentive adjustments ended in CY 2021. Medicare is currently the one remaining program with only a downward payment adjustment.

The HITECH Act authorized incentive payments under Medicare and Medicaid for the adoption and meaningful use of certified electronic health record technology (CEHRT). Incentive payments under Medicare were available to eligible hospitals and CAHs for certain payment years (as authorized under sections 1886(n) and 1814(l) of the Act, respectively) if they successfully demonstrated meaningful use of CEHRT, which included reporting on eCQMs using CEHRT. Incentive payments were available to MA organizations under section 1853(m)(3) of the Act for certain affiliated hospitals that successfully demonstrate meaningful use of CEHRT. In accordance with the timeframe set forth in the statute, these incentive payments under Medicare are no longer available. The last reporting year that Puerto Rico eligible hospitals could receive an incentive payment was in 2020 (FY 2021 payment year), and reporting year 2021 (FY 2022 payment year) is the first year where they would be subject to a downward/negative payment adjustment for failing to demonstrate meaningful use of CEHRT.

Sections 1886(b)(3)(B)(ix) and 1814(l)(4) of the Act also establish downward payment adjustments under Medicare, beginning with FY 2015, for eligible hospitals and CAHs that do not successfully demonstrate meaningful use of CEHRT for certain associated EHR reporting periods. Section 1853(m)(4) of the Act establishes a negative payment adjustment to the monthly prospective payments of a qualifying MA organization if its affiliated eligible hospitals are not meaningful users of CEHRT, beginning in 2015.

10. Confidentiality

We pledge privacy to the extent provided by law. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted. 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 data collected will be for CMS internal use only and will not be published, except as finalized for public display under section 1886(n)(4)(B) of the Social Security Act, which requires the Secretary to post on the CMS website, in an easily understandable format, a list of the names of the eligible hospitals and CAHs that are meaningful EHR users, and other relevant data as determined appropriate by the Secretary.

11. Sensitive Questions

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

12. Burden Estimate (Total Hours and Wages)

a. Background

The information collection requirements and associated burden due to the updates for the Medicare Promoting Interoperability Program are discussed in detail in the FY 2023 IPPS/LTCH PPS Final Rule. As a result, we are modifying the burden estimates.

In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45514), our burden estimates were based on an assumption of 3,300 eligible hospitals. We have determined that our assumption was in error as we inadvertently omitted the number of CAHs in our estimate. For this final rule, we are updating our assumption to 3,150 eligible hospitals and 1,350 CAHs based on data from the FY 2020 EHR reporting period, for a total number of 4,500 respondents. We are making this adjustment to reflect the total number of potential hospitals that could report under the Medicare Promoting Interoperability Program.

In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45516), 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 $20.50 per hour. We note that since then and as of the publication date of the FY 2023 IPPS/LTCH PPS proposed rule, more recent wage data from the Bureau of Labor Statistics have become available, reflecting a median hourly wage of $21.20 per hour. 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 ($21.20 × 2 = $42.40) to estimate total cost is a reasonably accurate estimation method. As a result of the availability of this more recent wage data, we have updated the wage rate used in these calculations in the FY 2023 IPPS/LTCH PPS final rule and this corresponding PRA package to $42.40.

Table 1 below summarizes the currently approved burden for the CY 2022 EHR Reporting Period:

Table 1: Medicare Promoting Interoperability Program Estimated Annual Information Collection Burden Per Respondent for the CY 2022 EHR Reporting Period:

Objective	Measure	Burden Estimate per Eligible Hospital/CAH

Protect Patient Health Information	Security Risk Analysis	6 hours
	SAFER Guides	1 minute
Electronic Prescribing	e-Prescribing	10 minutes
	Query of PDMP (BONUS)	
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	10 minutes
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	
	OR	
	Health Information Exchange Bi-Directional Exchange	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	10 minutes
Public Health and Clinical Data Exchange	Report the following 4 measures: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting	2 minutes
	Report one of the following measures (BONUS): • Public Heath Registry Reporting • Clinical Data Registry Reporting	
Total Burden Estimate per Respondent		6 hours 33 minutes

b. Measure Reporting and Submission Requirements for the Protect Patient Health Information Objective

We continue to estimate it will require eligible hospitals and CAHs approximately 6 hours to conduct or review a security risk analysis including addressing the security (to include encryption) of data created or maintained by CEHRT, implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process as finalized in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017 final rule (80 FR 62917).

We also continue to estimate it will require eligible hospitals and CAHs approximately 1 minute to respond "yes" or "no" for the SAFER Guides Reporting measure as finalized in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45515).

We estimate the total burden for this Objective to be 27,075 hours (6.017 hours x 4,500 hospitals) at a cost of $1,147,980 (27,075 hours x $42.40/hour).

c. Measure Reporting and Submission Requirements for the Electronic Prescribing Objective

We continue to estimate that eligible hospitals and CAHs would require 10 minutes to report the Electronic Prescribing measure as finalized in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017 final rule (80 FR 62917).

In the FY 2020 IPPS/LTCH PPS final rule, we estimated the burden associated with reporting the Electronic Prescribing Objective and associated measures to be 10 minutes (84 FR 42608) coinciding with the finalized change to the Query of PDMP measure to require a "yes/no" response instead of a numerator/denominator manual calculation. However, the burden associated with the Query of PDMP measure was not accounted for in the burden estimate of 10 minutes for this Objective in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42608 through 42609, the FY 2021 IPPS/LTCH PPS final rule (85 FR 59014), or the FY 2022 IPPS/LTCH PPS final rule (86 FR 45516). In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45464), we finalized that the Query of PDMP measure will remain optional. As a result of the finalized policy to require the Query of PDMP measure beginning in CY 2023 and considering the burden estimate of 30 seconds (0.5 minutes) for similar "yes/no" response measures for the Public Health and Clinical Data Exchange Objective, we are updating our burden estimate for the Electronic Prescribing Objective to 10.5 minutes to reflect the additional burden for reporting of the Query of PDMP measure.

As a result of this finalized policy and based on our updated burden estimate per measure, we are increasing our burden estimate for the Electronic Prescribing Objective from 10 minutes to 10.5 minutes (0.175 hours) to report both the e-Prescribing and Query of PDMP measures. Therefore, we estimate a total information collection burden of 788 hours across all eligible hospitals and CAHs (0.175 hours × 4,500 eligible hospitals and CAHs) annually at a cost of $33,390 (788 hours x $42.40/hour).

d. Measure Reporting and Submission Requirements for the Health Information Exchange Objective

We finalized in the FY 2022 IPPS/LTCH PPS final rule that eligible hospitals and CAHs may elect to report either the Health Information Exchange (HIE) Bi-Directional Exchange measure as a yes/no attestation to the HIE Objective as an optional alternative to the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures (86 FR 45465 through 45470). In the FY 2023 IPPS/LTCH PPS final rule, we are adding the Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) measure beginning in the CY 2023 EHR reporting period as an optional alternative to the three existing measures (Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure, or the HIE Bi-Directional

Exchange measure) and updating the scoring methodology for the Health Information Exchange Objective beginning with EHR reporting period in the CY 2023.

We continue to estimate eligible hospitals and CAHs will require 10 minutes (0.167 hours) to report one of the three alternatives. Therefore, we estimate a total information collection burden for this Objective of 750 hours (0.167 hours x 4,500 hospitals) at a cost of $31,800 (750 hours x $42.40/hour).

e. Measure Reporting and Submission Requirements for the Provider to Patient Exchange Objective

We continue to estimate eligible hospitals and CAHs will require 10 minutes (0.167 hours) to report the Provide Patients Electronic Access to Their Health Information measure. We are not finalizing any changes to this requirement. Therefore, we estimate a total information collection burden for this Objective of 750 hours (0.167 hours x 4,500 hospitals) at a cost of $31,800 (750 hours x $42.40/hour).

f. Measure Reporting and Submission Requirements for the Public Health and Clinical Data Exchange Objective

In the FY 2022 IPPS/LTCH PPS final rule, we finalized an increase in the number of measure eligible hospitals and CAHs are required to report from 2 to 4 (86 FR 45515). We also increased our burden estimate from 1 minutes to 2 minutes annually to report 4 measures. In the FY 2023 IPPS/LTCH PPS final rule, we are requiring a new AUR surveillance measure for eligible hospitals and CAHs under this objective beginning with the CY 2024 EHR reporting period. Eligible hospitals and CAHs will be required to attest to active engagement with CDC's National Healthcare Safety Network (NHSN) to submit AUR data and receive a report from NHSN indicating their successful submission of AUR data for the EHR reporting period. This policy requires eligible hospitals and CAHs to report 5 measures annually with a corresponding burden of 2.5 minutes (0.0417 hours) per hospital. The total annual burden across all eligible hospitals and CAHs is estimated to be 188 hours (0.0417 hours x 4,500 hospitals) at a cost of $7,950 (188 hours x $42.40/hour). The burden associated with the actual submission of AUR data to NHSN is accounted for under OMB control number 0920-0666.

We are also finalizing in the FY 2023 IPPS LTCH/PPS final rule to require eligible hospitals and CAHs to submit their level of engagement for the measures under the Public Health and Clinical Data Exchange Objective, either Pre-production and Validation or Validated Data Production. This requirement would be in addition to submitting responses for the required measures and the optional measures, if applicable. We believe the burden associated with this requirement is similar to the burden associated with the attestation that eligible hospitals and CAHs must complete for the four previously finalized measures under this Objective. Therefore, we estimate the burden associated with this new requirement to be 30 seconds or 0.5 minutes per eligible hospital or CAH annually. We estimate a total increase in burden of 38 hours across all

eligible hospitals and CAHs (0.5 minutes/hospital × 4,500 eligible hospitals and CAHs) annually at a cost of $1,611 (38 hours x $42.40/hr).

The total annual burden per eligible hospital and CAH for this Objective is estimated to be 3 minutes (0.05 hours). Across all eligible hospitals and CAHs, we estimate a total annual burden of is 225 hours (0.05 hours x 4,500 hospitals) at a cost of $9,540 (225 hours x $42.40/hour).

g. eCQM Measure Reporting and Submission Requirements

In the FY 2023 IPPS/LTCH PPS final rule, we are modifying our eCQM reporting and submission requirements whereby we are increasing the total number of eCQMs to be reported from four to six eCQMs beginning with the CY 2024 reporting period. We are also finalizing that the six eCQMs must be comprised of: (1) Three self-selected eCQMs; (2) the Safe Use of Opioids—Concurrent Prescribing eCQM; (3) the Severe Obstetric Complications eCQM; and (4) the Cesarean Birth eCQM, for a total of six eCQMs.

We previously finalized in the FY 2021 IPPS/LTCH PPS final rule that, for the CY 2023 reporting period, eligible hospitals and CAHs are required to submit data for three self-selected eCQMs each year and the Safe Use of Opioids-Concurrent Prescribing eCQM for a total of four eCQMs (85 FR 58975). We also finalized in the FY 2021 IPPS/LTCH PPS final rule to require eligible hospitals and CAHs to submit four quarters of eCQM data beginning in the CY 2023 reporting period (85 FR 58975). We continue to estimate the information collection burden associated with the eCQM reporting and submission requirements to be 10 minutes per measure per quarter. The burden associated with the reporting of eCQM measures for 3,150 eligible hospitals and 1,350 CAHs as part of the Hospital Inpatient Quality Reporting program is included under OMB control number 0938-1022 (CAHs are referred to as non-IPPS hospitals under OMB 0938-1022).

h. Burden Estimate Summary

We estimate the total annual burden for all participants in the Medicare Promoting Interoperability Program represents a total of approximately 29,588 hours for all eligible hospitals and CAHs (6.575 hours x 4,500 eligible hospitals and CAHs) at a total cost of $1,254,510 (29,588 hours x $42.40/hour).

Tables 2 and 3 below reflect the changes in burden for the CY 2023 EHR Reporting Period and the CY 2024 EHR Reporting Period and subsequent years due to policies in the FY 2023 IPPS/LTCH PPS final rule.

We are revising the information collection request under OMB control number 0938-1278. These burden estimates exclude burden associated with the reporting of electronic clinical quality measures for eligible hospitals under OMB control number 0938-1022, as Medicare hospitals report the data to CMS once per year for credit under both the

Hospital Inpatient Quality Reporting Program and the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

Table 2: Medicare Promoting Interoperability Program Estimated Annual Information Collection Burden Per Respondent for the CY 2023 EHR Reporting Period and Subsequent Years:

Objective	Measure	Burden Estimate per Eligible Hospital/CAH
Protect Patient Health Information	Security Risk Analysis	6 hours
	SAFER Guides	1 minute
Electronic Prescribing	e-Prescribing	10.5 minutes
	Query of PDMP	
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	10 minutes
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	
	OR	
	Health Information Exchange Bi-Directional Exchange	
	OR	
	Enabling Information Exchange Under TEFCA measure	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	10 minutes
Public Health and Clinical Data Exchange	Report the following 4 measures: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting	2.5 minutes
	Submit Level of Active Engagement	
	Report one of the following measures (BONUS): • Public Heath Registry Reporting • Clinical Data Registry Reporting	
Total Burden Estimate per Eligible Hospital and CAH		**6 hours 34 minutes**

Table 3: Medicare Promoting Interoperability Program Estimated Annual Information Collection Burden Per Respondent for the CY 2024 EHR Reporting Period and Subsequent Years:

Objective	Measure	Burden Estimate per Eligible Hospital/CAH
Protect Patient Health Information	Security Risk Analysis	6 hours
	SAFER Guides	1 minute
Electronic Prescribing	e-Prescribing	10.5 minutes
	Query of PDMP	
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	10 minutes
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	
	OR	
	Health Information Exchange Bi-Directional Exchange	
	OR	
	Enabling Information Exchange Under TEFCA measure	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	10 minutes
Public Health and Clinical Data Exchange	Report the following 5 measures: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AUR Surveillance Measure	3 minutes
	Submit Level of Active Engagement	
	Report one of the following measures (BONUS): • Public Heath Registry Reporting • Clinical Data Registry Reporting	
Total Burden Estimate per Eligible Hospital and CAH		**6 hours 35 minutes**

13. Capital Costs (Maintenance of Capital Costs)

We are adopting a new Antimicrobial Use and Resistance (AUR) Surveillance measure for eligible hospitals and CAHs under the Promoting Interoperability Program's Public Health and Clinical Data Exchange Objective beginning in the CY 2024 reporting period. In order to attest successfully, an eligible hospital or CAH must be in active engagement with CDC's NHSN to submit AUR data and receive a report from NHSN indicating their successful submission of AUR data for the EHR reporting period. Participation in NHSN's surveillance requires the purchase or building of an AUR reporting solution. While thousands of hospitals have voluntarily done this to date, for hospitals who would be required to, we estimate the cost to range between $17,000 and

$388,500 annually, with a median of $187,400[1]. We believe these associated costs are outweighed by the more than $4.6 billion in health care costs spent annually treating antibiotic resistance threats[2].

14. Cost to the Federal Government

To collect the required information, the cost to the Federal Government (CMS) is minimal, as these data will be collected in a system that is currently operating to support different hospital quality reporting programs. We note that we are currently collecting these data with the Hospital Quality Reporting system, which eligible hospitals and CAHs access via the QualityNet secure portal.

15. Program or Burden Changes

We estimate the total annual burden for all participants in the Medicare Promoting Interoperability Program to be 29,588 hours at a total cost of $1,254,510 (29,588 hours x $42.40/hour). This is an increase of 8,138 hours and $345,030 from the currently approved information collection burden of 21,450 hours at a cost of $909,480 (adjusted for increased wage rate).

Given the policies in the FY 2023 IPPS/LTCH PPS final rule, we estimate a total burden estimate of 6 hours 35 minutes per eligible hospital and CAH, which is a slight increase of 1.5 minutes per eligible hospital and CAH from the FY 2022 IPPS/LTCH PPS Final Rule (86 FR 45515). The increase of 1.5 minutes is due to an adjustment in the burden estimate for the Query of PDMP measure as well as increases due to the AUR Surveillance measure and the requirement to submit level of active engagement.

16. Publication and Tabulation Dates

Information will be viewable on the Medicare Promoting Interoperability Program website[3]. The information for public viewing available on this site is geared toward educational and contextual assistance for those learning about the program including but not limited to: latest news, dates to remember, program requirements, contact information, as well as useful links to the Federal Register, FAQ, and objective-measure specification sheets.

17. Expiration Date

There are no additional forms associated with this information collection request besides the online form used for submitting attestations. We plan to post the PRA disclosure statement including the expiration date on the cms.gov website, https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html.

18. Certification Statement

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5051263/

[2] https://www.cdc.gov/drugresistance/solutions-initiative/stories/partnership-estimates-healthcare-cost.html

[3] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

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