Supporting Statement – Part A

Requirements for Hospitals to Make Public a List of Their Standard Charges CMS-10707/OMB control number # 0938-1369

A. Background

The Centers for Medicare & Medicaid Services (CMS) finalized new rules, at 45 CFR part 180, authorized by section 2718 of the Public Health Service (PHS) Act. Section 2718(e) of the PHS Act requires each hospital operating within the United States for each year to establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act (the Act). The data collection includes establishing, updating, and making public via the internet in a single machine-readable file a list of standard charges (including gross charges, payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash prices) for all items and services. The data collection also includes hospitals making public via the internet standard charges (including payer-specific negotiated charges, discounted cash prices, de-identified minimum negotiated charges, de-identified maximum negotiated charges) in a consumer-friendly manner for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.

In the CY 2022 OPPS/ASC final rule with comment period (86 FR 63941), CMS strengthened the hospital price transparency (HPT) enforcement scheme in order to improve compliance rates and made other updates to the requirements. Specifically, we (1) increased the penalty amount for noncompliance through the use of a scaling factor based on hospital bed count; (2) deemed state forensic hospitals that meet certain requirements to be in compliance with the requirements of 45 CFR part 180, and (3) prohibited certain conduct that we concluded were barriers to accessing the standard charge information, including, specifically, prohibiting hospitals from coding their machine readable file (MRF) in a fashion that made it inaccessible to automated searches and direct downloads.

In the CY 2024 OPPS/ASC proposed rule, CMS is proposing to amend several of the HPT requirements in order to improve our monitoring and enforcement capabilities by way of improving access to, and the usability of, hospital standard charge information; reduce the compliance burden on hospitals by requiring the use of standard templates and providing technical guidance for display of hospital standard charge information; align, where feasible, certain hospital price transparency requirements and processes with requirements and processes we have implemented in the Transparency in Coverage (TIC) initiative; and make other modifications to our monitoring and enforcement capabilities that will, among other things, increase its transparency to the public. Specifically, we proposed to: (1) add definitions for "CMS template", "consumer-friendly expected allowed charges", "encode", and "machine-readable file" (MRF); (2) require hospitals to affirm the accuracy and completeness of data in their MRF; (3) revise and expand the data elements hospitals must include in the MRF; (4)

require hospitals to conform to a CMS template layout and other technical specifications for encoding standard charge information in the MRF; (5) require hospitals to establish and maintain a txt file and footer as specified by CMS; and (6) revise our enforcement process by updating our methods to assess hospital compliance, requiring hospitals to acknowledge receipt of warning notices, working with health system officials to address noncompliance issues in one or more hospitals that are part of a health system, and publicizing more information about CMS enforcement activities related to individual hospital compliance. Additionally, we are seeking comment on additional considerations for improving compliance and aligning consumer-friendly policies and requirements with other federal price transparency initiatives.

B. Justification

1. Need and Legal Basis

Section 1001 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by section 10101 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), amended Title XXVII of the PHS Act, in part, by adding a new section 2718(e). Section 2718 of the PHS Act, entitled "Bringing Down the Cost of Health Care Coverage," requires each hospital operating within the United States for each year to establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Act.

On November 27, 2019, the final rule entitled "Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public" (herein referred to as the CY2020 HPT Final Rule) was published in the Federal Register. With the CY2020 HPT Final Rule, CMS finalized a new Part 180--Hospital Price Transparency to Title 45 of the Code of Federal Regulations (CFR) which contains regulations on price transparency for purposes of section 2718(e) of the PHS Act. These requirements build upon previous guidance that required hospitals to make public their standard charges upon request starting in 2015 (79 FR 50146) and subsequently online in a machine- readable format starting in 2019 (83 FR 41144), and consider public comments received on the proposals in the CY 2020 OPPS/ASC proposed rule (84 FR 39398). The final rule includes information collections associated with the following: requirements specified in §180.50 for a "hospital" (as defined in §180.20) to make public a machine-readable file that contains a hospital's gross charge, payer-specific negotiated charge, the de-identified minimum negotiated charge, the de-identified maximum negotiated charge, and discounted cash price for all "items and services" (as defined in §180.20) provided by the hospital; and requirements specified in
§180.60 for a hospital to make public payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash prices for at least 300 select hospital-provided items and services that are "shoppable" and that are displayed and packaged in a consumer-friendly manner.

The CY2020 HPT Final Rule also established new regulations at 45 CFR 180 Subpart C to provide for monitoring and enforcement activities. These activities may require hospitals to

submit documentation to CMS, such as in response to a corrective action plan request, or other data collections necessary for CMS to monitor and assess compliance with the regulatory disclosure requirements.

In the CY2024 OPPS/ASC proposed rule, CMS is making proposals to further specify how hospitals make public their standard charges in a machine-readable file under 45 CFR 180.50 and increase CMS' ability to enforce the disclosure requirements under 45 CFR 180.70. CMS is proposing to revise regulations at 45 CFR 180.50 related to making public hospital standard charges in an MRF. First, we are proposing to add data elements to be included in the hospital's MRF and to require hospitals to conform to a CMS template layout. Second, to enhance automated access to the MRF, we are proposing that hospitals include a txt file in the root folder of the public website it selects to host its MRF in the form and manner specified by CMS that includes a standardized set of fields, and a link in the footer on its website that is labeled "Hospital Price Transparency" and links directly to the publicly available webpage that hosts the link to the MRF. These proposals are directly responsive to public input received through previous requests for information and recommendations from the HHS Health Federally Funded Research and Development Center (FFRDC) that convened industry experts to explore what data elements would be necessary to improve the public's understanding of the standard charges established by hospitals and to maximize use of the data. CMS believes these proposals will improve hospitals' ability to comply and the public's ability to aggregate the information, enhance automated accessibility to hospital standard charges information, and streamline CMS's ability to enforce the requirements.

CMS is proposing at new § 180.70(a)(2)(iv) to require an authorized hospital official to submit to CMS a certification to the accuracy and completeness of the standard charges information posted in the MRF at any stage of the monitoring, assessment, or compliance phase. CMS is proposing at § 180.70(b)(1) that CMS will require that a hospital submit an acknowledgement of receipt of the warning notice in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital. These proposals are designed to improve CMS enforcement capabilities.

2. Information Users

Collection of this information is necessary for CMS to ensure pricing information is readily accessible and usable to the public, and to ensure compliance. Health care consumers continue to lack the meaningful pricing information they need to choose the healthcare services they want and need despite prior requirements for hospitals to make public their chargemaster rates online. The regulations requiring public release of hospital standard charge information is a necessary and important step in ensuring transparency in health care prices for consumers and other users of hospital standard charge information to help drive competition and reduce healthcare costs.

Hospitals: Hospitals are the only respondents for the purpose of this information collection. This regulation applies to each hospital operating within the United States. As specified in §180.40, a hospital is required to make public both of the following: (1) A machine-readable file containing a list of all standard charges for all items and services as provided in §180.50, and (2) a

consumer-friendly list of standard charges for a limited set of shoppable services as provided in §180.60. CMS believes that these two different methods of making hospital standard charges public are necessary to ensure such data is available to consumers where and when it is needed (for example, via integration into price transparency tools, Electronic Health Records (EHRs), and consumer apps), and also directly available and useful to consumers that search for hospital-specific charge information without use of a developed price transparency tool. We believe that requiring hospitals to make public standard charges for shoppable services will increase consumer satisfaction and encourage price comparison, ultimately resulting in decreased out-of-pocket cost to the consumer. Additionally, in 45 CFR 180 Subpart C, CMS enforces the regulatory disclosure requirements and may require hospitals to submit information to CMS in order for CMS to monitor and assess hospital compliance.

Health Care Consumers: CMS intends for consumers to have easier access to health care pricing information in a consumer-friendly format, including payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash prices for shoppable services. Consumers will have a better ability to estimate their hospital bills prior to treatment.

Third party developers, researchers, states and employers: Third party developers will have access to all gross charges, payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted cash prices, and may innovate and create new products, including Internet-based price estimator tools, or upgrade existing technologies to support hospitals in meeting these requirements and aiding consumers and healthcare providers in using data that is made public by hospitals. Researchers will have better information on regional and local health care costs which may lead to a better understanding of price dispersion and economic factors that result in artificially inflated costs. States may use the information to inform policymaking and help state agencies better understand what is driving rising hospital costs. Other members of the public, such as employers, would be better informed to monitor insurer effectiveness and to help their employees shop for value.

CMS: CMS will use the data to monitor and enforce the HPT requirements and inform policymaking. Consumers (individuals) or entities may review the publicly available information and report to CMS findings that suggest a hospital's noncompliance with the regulations.

3. Use of Information Technology

Generally, under the current regulations, hospitals must make public information about their standard charges on the internet in a machine-readable file format (45 CFR 180.50). Additionally, a subset of the data (shoppable services) must be made available in a consumer-friendly format (45 CFR 180.60).

In the CY2024 OPPS/ASC proposed rule, CMS is proposing to modify 45 CFR 180.50 to require that the hospital's machine-readable file conform to the CMS template layout, data specifications, and data dictionary for purposes of making public the standard charge information, and include an expanded set of data elements required under 180.50(b) that CMS has determined are necessary to improve the public's understanding of the standard charges the hospital has established. CMS defines a machine-readable format as a digital representation of

data or information in a file that can be imported or read into a computer system for further processing. Requiring hospitals to post a list of their standard charges in a machine-readable format ensures that standard charge data can be accessible to the public, including third party developers who may use such data to create consumer-friendly price transparency tools. CMS is also proposing at new § 180.50(a)(3) that the hospital must include a statement in its machine-readable file affirming that the hospital, to the best of its knowledge and belief, has included all applicable standard charge information in accordance with the requirements of 45 CFR 180.50, and that the information displayed is true, accurate, and complete as of the date indicated in the file.

In the CY2024 OPPS/ASC proposed rule, CMS is proposing at new § 180.50(d)(6) to require that a hospital ensure that the public website it chooses to host the MRF establishes and maintains automated access to the MRF in two specific ways. First, CMS is proposing at new § 180.50(d)(6)(i) that the hospital ensure the public website includes a .txt file in the root folder that includes a standardized set of fields including the hospital location name that corresponds to the MRF, the source page URL that hosts the MRF, a direct link to the MRF (the MRF URL), and hospital point of contact information. Second, CMS is proposing at new § 180.50(d)(6)(ii) that the hospital ensure the public website includes a link in the footer on its website, including but not limited to the homepage, that is labeled "Hospital Price Transparency" and links directly to the publicly available webpage that hosts the link to the MRF. CMS believes these proposals will improve automated accessibility to hospital standard charges information and streamline the ability of CMS to enforce the requirements.

In the CY2024 OPPS/ASC proposed rule, CMS is proposing at new § 180.70(a)(2)(iv), to require an authorized hospital official to submit to CMS a certification to the accuracy and completeness of the standard charges information posted in the MRF at any stage of the monitoring, assessment, or compliance phase. CMS is also proposing at new § 180.50(a)(3) that the hospital affirm within the MRF the accuracy and completeness of the standard charges information. We believe that this additional authority to require a formal certification by an authorized official is necessary to assist CMS in enforcement of the regulations when questions or complaints arise about the completeness or accuracy of the data. This certification authority is necessary because CMS may need a formal certification to resolve any specific questions related to the standard charges displayed and the items and services for which the hospital has established a standard charge, which might not be answered by the proposed affirmation statement in § 180.50(a)(3)

In the CY2024 OPPS/ASC proposed rule, CMS is proposing at § 180.70(b)(1) that CMS will require that a hospital submit an acknowledgement of receipt of the warning notice in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital. As part of the confirmation of receipt, we may request contact information from the hospital to streamline further communications.

4. Duplication of Efforts

We anticipate no duplication of efforts for hospitals. The required hospital information collection is distinguishable from other federal efforts, and flexibility is afforded in the CY2020 HPT Final

Rule to allow hospitals to use already existing platforms for making a list of standard charges public to avoid duplication of State and private sector efforts aimed to improve price transparency. Additionally, as specified in the regulation, CMS will deem a hospital as having met the requirements for making public standard charges in a consumer-friendly manner if the hospital maintains an internet-based price estimator tool which meets the requirements as specified in §180.60. In light of more recent federal price transparency efforts, the OPPS/ASC proposed rule includes a request for information from the public related to alignment with provisions under both the Transparency in Coverage regulations and the No Surprises Act.

5. Small Businesses

The proposed rule applies to all hospitals, including small rural hospitals. However, we determined that the requirements included in the proposed rule will not have a significant impact on a substantial number of small entities.

6. Less Frequent Collection

Less frequent collection would not be an option because section 2718(e) of the PHS Act requires each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Act. Therefore, in accordance with the statute, the regulation at 45 CFR 180.50(e) and 180.60(e) require hospitals to update the standard charge information at least once annually.

As described in the CY2020 HPT final rule, CMS recognizes that hospital charges may change more frequently than annually, and therefore encourages (but does not require) hospitals to update the standard charge data they make public more often, as appropriate, so that the public may have access to the most up-to-date charge information.

7. Special Circumstances

This collection of information does not require any special circumstances.

8. Federal Register/Outside Consultation

Federal Register

The 60-day notice published as part of the notice of proposed rulemaking that published on July 31, 2023 (88 FR 49552)[1] in the Federal Register.

[1] https://www.govinfo.gov/content/pkg/FR-2023-07-31/pdf/2023-14768.pdf

In the CY 2022 OPPS/ASC proposed rule (86 FR 42321), we sought public comment on improving standardization of the data disclosed by hospitals in the MRF. In response, many commenters urged CMS to create a standard template for hospitals to use for posting their MRF, noting that such standardization could ease operational burdens, improve the public's (including employers and researchers) ability to make price comparisons across hospitals, and better enable third party data aggregation services to develop user-friendly consumer tools for displaying this information. Some commenters recommended that CMS work with providers and vendors to better understand the benefits of a standard template. Some hospitals also urged CMS to be more prescriptive, requesting that CMS standardize the MRF format and contents and provide additional clarification on how hospitals should indicate that they have not established all five types of standard charges for a particular listed item or service.

As a result of these comments, we requested the HHS Health Federally Funded Research and Development Center (FFRDC)[1] to more fully explore the feasibility of these commenters' recommendations, and to identify technical specifications and categories of information (referred to as "data elements") that we could consider proposing in future rulemaking to improve the usability and meaningfulness of the standard charges display. The Health FFRDC convened a technical expert panel (TEP) and used the TEP members' advice to make informed recommendations to CMS in the summer of 2022. The TEP was comprised of both MRF developers, specifically, hospitals (representatives of large and small acute and specialty care hospitals), and primary users of MRF data, specifically, researchers and information technology innovators. Ultimately, the Health FFRDC, as informed by TEP members, recommended to CMS that CMS provide hospitals with an option to use one of three layouts representing two types of machine-readable formats for displaying their standard charge information in an MRF: (1) JSON schema (plain format), (2) CSV ("tall" format), or (3) CSV ("wide" format). TEP members indicated that this choice would balance the need for greater standardization for automated machine use of the files, while providing a hospital some flexibility to select the least burdensome format and layout to incorporate into its current MRF development process. Additionally, the Health FFRDC, as informed by the TEP, recommended expansion of the required data elements to improve the meaningfulness and facilitate automated aggregation of hospital standard charges. In the CY2024 OPPS/ASC proposed rule, we are therefore proposing to require that the hospitals' machine-readable file conform to the CMS template layout, data specifications, and data dictionary for purposes of making public the standard charge information, including display of an expanded set of data elements recommended by the Health FFRDC.

9. Payments/Gifts to Respondents

No payments or gifts will be given to respondents for participation.

10. Confidentiality

[1] MITRE operates HHS' Health FFRDC, a federally funded research and development center. For more information, see: https://www.mitre.org/our-impact/rd-centers/health-ffrdc

All information collected under this information collection will be maintained in strict accordance with statutes and regulations governing confidentiality requirements. In addition, the tools used for transmission of data are considered confidential forms of communication and are Health Insurance Portability and Accountability Act (HIPAA) and Privacy Act of 1974 (5 U.S.C. 552a) compliant.

11. Sensitive Questions

There are no sensitive questions associated with this collection.

12. Burden Estimates (Hours & Wages)

In the final rule dated November 2019 (84 FR 65524) (herein referred to as the CY 2020 HPT final rule), we adopted requirements for hospitals to make public their standard charges in two ways: (1) as a comprehensive machine-readable file (MRF); and (2) in a consumer-friendly format. We codified these requirements at new 45 CFR part 180.50 and 180.60, respectively.

We originally estimated the number of hospitals to be 6,002. We finalized an initial one-time burden of 150 hours and cost of $11,898.60 per hospital, resulting in a total national burden of 900,300 hours (150 hours x 6,002 hospitals) and $71,415,397 ($11,898.60 x 6,002 hospitals) to build processes and make required system updates to make their standard charge data publicly available: 1) as a comprehensive machine-readable file and 2) in a consumer-friendly format. Additionally, we estimated an on-going annual burden of 46 hours per hospital with a cost of $3,610.88 per hospital, resulting in a total national burden of 276,092 hours (46 hours x 6,002 hospitals) and total cost of $21,672,502 ($3,610.88 x 6,002 hospitals), to make required annual updates to the hospital's standard charge data information. For a detailed discussion of the cost estimates for the requirements related to hospitals making their standard charge data publicly available we refer readers to our discussion in the collection of information section in the CY 2020 HPT final rule (84 FR 65591 through 65596).

We are increasing the number of hospitals we believe to be subject to these requirements from 6,002 to 7,098 which would increase the estimated national burden. In the CY 2020 HPT final rule (84 FR 65591), we estimated that 6,002 hospitals would be subject to the hospital price transparency requirements. To derive the estimated number, we relied on data from the American Hospital Association (AHA).[2] For this collection of information estimate, we are using updated hospital numbers based on the publicly available dataset from the Homeland Infrastructure Foundation-Level Data (HIFLD) [3] hospital dataset because the HIFLD dataset compiles a directory of hospital facilities based on data acquired directly from state hospital licensure information and federal sources, and validates this data annually. Thus, we believe the HIFLD dataset is more accurate than the AHA Directory. The source data was available in a variety of formats (pdfs, tables, webpages, etc.) which is reviewed and geocoded and then

[2] American Hospital Association. Fast Facts on U.S. Hospitals, 2019. Available at: https://www.aha.org/statistics/fast-facts-us-hospitals. The AHA listed 6,210 total hospitals operating in the US. To arrive at 6,002 hospitals, we subtracted the 208 federally owned or operated hospitals.

[3] Homeland Infrastructure Foundation-Level Data hospital dataset accessed on May 3, 2023, located at https://hifld-geoplatform.opendata.arcgis.com/datasets/hospitals/data

converted into a spatial database. To estimate the number of hospitals subject to these requirements, we leveraged the HIFLD hospital dataset to identify 8,013 total hospitals. We then subtracted out 379 hospitals HIFLD identified as "closed" as well as hospitals that are deemed under the regulation to have met requirements (see 45 CFR 180.30) which included 339 federally owned non-military and military hospitals, and 197 state, local, and district run forensic hospitals. We therefore estimate that this proposed rule applies to 7,098 hospitals operating within the United States under the definition of "hospital." Finally, we estimate the hourly cost for each labor category used in this analysis by referencing Bureau of Labor Statistics report on Occupational Employment and Wages (May 2022) [4] in Table 1.

TABLE 1: OCCUPATION TITLES AND WAGE RATES

Occupational Title	Occupation code	Mean hourly wage ($/hr)	Fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
General and Operations Managers	BLS 11-1021	$59.07	$59.07	$118.14
Business Operations Specialists	BLS 13-1000	$40.04	$40.04	$80.08
Network and Computer Systems Administrators	BLS 15-1244	$46.71	$46.71	$93.42

First, we believe that hospitals would incur a one-time cost to update their processes and systems to 1) identify and collect the standard charge information represented by the newly proposed data elements, and 2) to conform the standard charge information for both the existing and newly proposed data elements in the proposed CMS template layout. To implement these requirements, we estimate that it would take, on average, 1 hour (at a cost of $118.14 per hour) for a General and Operations Manager (BLS 11-1021) to review and determine proposed compliance requirements. We estimate it will take a Business Operations Specialist (BLS 13-1000), on average, 10 hours (at a cost of $80.08 per hour) to develop and update the necessary processes and procedures and develop the requirements to implement the proposed CMS template. Once the existing systems have been identified and requirements developed, we estimate that a network and computer system administrator (BLS 15-1244) would spend, on average, 20 hours (at a cost of $93.42 per hour), to make updates to existing systems to conform to the proposed CMS template layout and post it to the internet, including developing and posting the proposed txt file in the root folder of the public webpage it selects to host its MRF in the form and manner specified by CMS that includes a standardized set of fields specified by this proposed rule. Therefore, we are proposing the total annual burden estimate for the first year to be 31 hours (1 hours + 10 hours + 20 hours) per hospital with a cost of $2,787.34 ($118.14 + $800.80+ $1,868.40) per hospital. The one-time national burden is calculated to be $19,784,539.32 dollars ($2,787.34 per hospital x 7,098 hospitals). (See Table 2.)

[4] U.S. Bureau of Labor Statistics, May 2022 national Occupational Employment and Wage Estimates United States, Occupational Employment and Wage Statistics. Accessed at https://www.bls.gov/oes/tables.htm

TABLE 2: SUMMARY OF INFORMATION OF COLLECTION BURDENS FOR THE FIRST YEAR

Regulation section	OMB control no.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Total labor cost of reporting ($)
§ 180.50	0938-1369	7,098	7,098	31	220,038	$19,784,539.32

In addition to the one-time cost to implement the proposed CMS template, we are providing a revised estimate of our annual burden estimates. As noted, we originally estimated an on-going annual burden of 46 hours, per hospital, for 6,002 hospitals to make annual updates to display their standard charge data. Originally, we estimated it would take on average: a general or operations manager 2 hours, per hospital, to review and determine updates in compliance with requirements; a business operations specialist 32 hours, per hospital, to gather and compile required information and post it to the internet; and a network and computer system administrator 12 hours to maintain requirements specified in the CY 2020 HPT final rule (84 FR 65596).

We estimate it will still take a general or operations manager 2 hours, per hospital, to review and determine updates in compliance with requirements. However, we now estimate an increased ongoing amount of time for a business operations specialist, from 32 hours to 40 hours per hospital, to identify and gather required additional data elements on an annual basis. This increase acknowledges that some hospitals may not update their systems in the first year to maintain and abstract newly required data elements in an automated way to facilitate future annual updates to the MRF, thus we expect a subset of hospitals will continue to spend time annually to gather their standard charge information. We continue to believe that it will take a computer system administrator 12 hours to maintain and post the MRF in a manner that conforms to the CMS template layout, which brings total burden per hospital to be 54 hours. Therefore, we estimate an annual national burden of 383,292 hours (54 hours x 7,098 hospitals) and an annual national cost of $32,370,571 dollars ($4,560.52 per respondent x 7,098 hospitals). This represents a $10,698,069 ($32,370,571 - $21,672,502) increase over our previous estimated national annual burden for subsequent years. We summarize our updated annual burden estimates in the Table 3 below.

TABLE 3: SUMMARY OF INFORMATION OF COLLECTION BURDENS FOR SUBSEQUENT YEARS

Regulation section	OMB control no.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Total labor cost of reporting ($)
§ 180	0938-1369	7,098	7,098	54	383,292	$32,370,571

For the purpose of OMB review and approval, the burden estimate is the average of the first year

and the first two subsequent year estimates because the maximum OMB approval period for an information collection request is three years. Therefore, we are requesting approval for 328,874 hours = (220,038 hours + 383,292 hours + 383,292 hours) ÷ 3 years).

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

To generate salary estimates, for the table below, we used hourly wage data from the https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/RUS_h.pdf published by the Office of Personnel Management (OPM) for the Washington-Baltimore-Arlington region. The table also estimates the average benefits, as a percentage of wages for federal employees, to be 80% according to a CBO study.[5]
These estimates are based on our experience with monitoring hospitals for compliance with the requirements of the HPT regulations over the past two years, and requiring additional compliance actions and imposing civil monetary penalties. Staffing estimates are based on CMS duties as follows:

- Investigative action if CMS receives a complaint. Clarify complaint, if necessary,
- Access, review and validate data posted on hospital website. Time estimate may vary depending on the validation procedures required.
- Notify hospital of noncompliance and need for corrective action: develop and send written warning notice and/or notice of violation requiring a corrective action plan (CAP); review and approve hospital's CAP; assist hospitals as needed to develop CAPs; monitor and evaluate hospital's compliance with the corrective action.
- Assessment of civil monetary penalties (CMPs), and posting of notice of assessment of CMPs on a CMS website and maintaining the website of these postings; responding to hospital appeals of CMPs and other legal issues.
- Provide policy guidance and technical assistance to stakeholders including hospitals, as needed.
- Provide publicly available information on best practices for hospitals to demonstrate procedures for maintaining compliance and highlight exemplars.
- This program takes 15 CMS staff at the following: 1 GS-9, 1 GS-12, 8 GS-13, 3 GS-14, and 2 GS-15 for a total cost of $3,007,91736.60, the breakdown of hours is presented below.

Estimate					
Staff	Hours	Wage	Benefits	Adjusted hourly wage	Total
GS-9, step 10	2,020	$35.58	$28.46	$64.04	$129,368.88
GS-12, step 1	2,020	$39.69	$31.75	$71.44	$144,312.84
GS-13, step 4	10,100	$51.91	$41.53	$93.44	$943,723.80
GS-13, step 9	4,040	$59.78	$47.82	$107.60	$434,720.16
GS-13, step 10	2,020	$61.35	$49.08	$110.43	$223,068.60

GS-14, step 2	2,020	$57.63	$46.10	$103.73	$209,542.68
GS-14, step 4	4,040	$61.35	$49.08	$110.43	$446,137.20
GS-15, step 4	2,020	$72.16	$57.73	$129.89	$262,373.76

[5] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/52637-federalprivatepay.pdf

GS-15, step 7	1,515	$78.72	$62.98	$141.70	$214,669.44
					$3,007,917.36

15. Changes to Burden

This is a revision of a previously approved information collection. The burden has increased by 107,200 hours (from 276,092 hours to 383,292). This is primarily due to an increase in the number of respondents required to post the required standard charge data and the additional time associated with posting the data. For the purpose of OMB review and approval, the burden estimate is the average of the first year and the first two subsequent year estimates because the maximum OMB approval period for an information collection request is three years. Therefore, we are requesting approval for 328,874 hours = (220,038 hours + 383,292 hours + 383,292 hours) ÷ 3 years).

16. Publication/Tabulation Dates

The results of this information collection will not be published.

17. Expiration Date

The expiration date will be displayed on the CMS.gov website.

18. Certification Statement

There are no exceptions to the certification statement.