Supporting Statement – Part A

Submission of Information for the Hospital Outpatient Quality Reporting (OQR) Program: CY 2024 OPPS/ASC Proposed Rule

A. Background

The Centers for Medicare & Medicaid Services' (CMS') quality reporting programs promote higher quality, more efficient healthcare for Medicare beneficiaries by collecting and reporting on quality-of-care metrics. This information is made available to consumers, both to inform Medicare beneficiaries' decision-making, as well as to incentivize healthcare facilities to make continued improvements.

Specifically, CMS has implemented quality measure reporting programs for multiple settings, including for hospital outpatient settings, to achieve its overarching priorities and initiatives, including the National Quality Strategy and the Meaningful Measure 2.0 Framework. In particular, Meaningful Measures 2.0 promotes innovation and modernization of all aspects of quality to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives by supporting five interrelated goals: (1) empower consumers to make good health care choices through patient-directed quality measures and public transparency, (2) leverage quality measures to promote health equity and close gaps in care, (3) streamline quality measurement, (4) leverage measures to drive outcome improvement through public reporting and payment programs, and (5) improve quality measure efficiency by transitioning to digital measures and using advanced data analytics.

The Hospital Outpatient Quality Reporting (OQR) Program was established under section 1833(t) of the Social Security Act (the Act). CMS began data collection under this program in calendar year (CY) 2008. As required by authorizing statute, these data have been made publicly available after providing hospital outpatient facilities the opportunity to review their data. Hospital OQR Program payment determinations are made based on reported quality measure data and submission of supporting forms, as specified through rulemaking. The information collection requirements for the CY 2014 through CY 2024 payment determinations are currently approved under OMB control number 0938-1109 (expiration date February 28, 2025). This request covers data collection requirements for CYs 2026 through 2029 payment determination and subsequent years.

B. Justification

1. Need and Legal Basis

The Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA)[1] section 109(a) amended section 1833(t) of the Act by adding a new subsection (17) that affects the payment rate update applicable to Outpatient Prospective Payment System (OPPS) payments for services furnished by hospitals in outpatient settings on or after January 1, 2009.

[1] (Pub. L. 109-432)

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

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus-building entities (CBE). Section 1833(t)(17)(C)(ii) of the Act allows the Secretary to select measures that are the same as (or a subset of) the measures for which data are required to be submitted under the Hospital Inpatient Quality Reporting Program.

Section 1833(t)(17)(D) of the Act gives the Secretary the authority to replace measures or indicators as appropriate, such as where all hospitals are effectively in compliance, or the measures or indicators have been subsequently shown not to represent the best clinical practice. Section 1833(t)(17)(E) of the Act requires the Secretary to establish procedures for making data submitted under the program developed for hospital outpatient settings available to the public. Such procedures include providing facilities with the opportunity to review their data prior to public release.

Continued expansion and refinement of the quality measure set is consistent with the letter and spirit of the authorizing legislation, MIEA-TRHCA, to collect and make publicly available hospital-reported information on the quality of care delivered in the hospital outpatient setting.

Hospital OQR Program Quality Measures

The Hospital OQR Program seeks to collect and publicly report data on quality-of-care measures for the hospital outpatient setting. Measure data are submitted via one of five modes: (1) chart-abstracted; (2) claims-based; (3) web-based; (4) digital; (5) and survey-based, as seen in Table 1.

For measure data submitted as “chart-abstracted,” information is derived through analysis of a patient’s medical record. Chart-abstracted data involves manual data entry effort and requires additional effort or burden from hospitals.

For measure data submitted as “web-based,” hospitals are required to submit aggregate chart-abstracted data directly to CMS via a web-based tool located on a CMS website. One web-based measure is submitted differently; specifically, the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure is calculated using data submitted to the Centers for Disease Control and Prevention’s (CDC) National Healthcare Safety Network (NHSN) under OMB control number 0920-1317 (expiration date January 31, 2024). We note that the CDC currently has a PRA waiver for the collection and reporting of vaccination data under section 321

of the National Childhood Vaccine Injury Act of 1986 (enacted on November 14, 1986) (NCVIA).[2]

For measure data submitted as "claims-based," information is derived through analysis of administrative Medicare Fee-for-Service (FFS) claims and beneficiary enrollment data and do not require additional effort or burden from hospitals.

For measure data submitted as "digital", such as electronic clinical quality measures (eCQMs), information is electronically extracted from electronic health records (EHRs) and/or health information technology (HIT) systems. Because patient data are already entered into EHRs and HITs as part of clinical practice, only the time associated with electronically submitting data to CMS is accounted for in our burden estimates.

For measure data submitted as "survey-based," information is derived through analysis of responses to the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey and require hospitals to administer the survey and submit the survey data to CMS. These survey administration burdens are captured under OMB control number 0938-1240, which expires November 30, 2024.

Table 1. Hospital OQR Program Measures for the CY 2025 Payment Determination

Measure Data Submission Mode and Name	CBE No.
Chart-Abstracted Measures	
Median Time for Discharged ED Patients (Previously referred to as Median Time from ED Arrival to ED Departure for Discharged ED Patients)	0496
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of emergency department Arrival	0661
Claims-Based Measures	
MRI Lumbar Spine for Low Back Pain	0514
Abdomen Computed Tomography (CT) - Use of Contrast Material	N/A
Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	0669
Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	2539
Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy	3490
Hospital Visits after Hospital Outpatient Surgery	2687
Breast Cancer Screening Recall Rates	N/A
Web-Based Measures	
Patient Left Without Being Seen	0499

[2] Pub. L. 99-660.

Measure Data Submission Mode and Name	CBE No.
Colonoscopy Follow-Up Interval (Previously referred to as Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients)	0658
Cataracts Visual Function (Previously referred to as Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery)*	1536
COVID-19 Vaccination Coverage Among Health Care Personnel**	3636
Digital/Electronic Clinical Quality Measures (eCQMs)	
ST-Segment Elevation Myocardial Infarction (STEMI)	N/A
Survey-Based Measures	
OAS CAHPS Survey OP-37a: About Facilities and Staff*** OP-37b: Communication about Procedure*** OP-37c: Preparation for Discharge and Recovery*** OP-37d: Overall Rating of Facility*** OP-37e: Recommendation of Facility***	N/A

*In the CY 2023 OPPS/ASC final rule, we maintain reporting for this measure as voluntary.
**Burden for this measure is accounted for under OMB control number 0920-1317.
***Reporting of these measures is voluntary for the CY 2023 reporting period/CY 2025 payment determination and mandatory beginning with the CY 2024 reporting period/CY 2026 payment determination.

In the CY 2024 OPPS/ASC proposed rule, we are proposing to modify three previously adopted measures: (1) COVID–19 Vaccination Coverage Among HCP measure, beginning with the CY 2024 reporting period/CY 2026 payment determination; (2) Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure, beginning with the voluntary CY 2024 reporting period; and (3) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure, beginning with the CY 2024 reporting period/CY 2026 payment determination.

We are also proposing to re-adopt with modification the Hospital Facility Volume Data on Selected Outpatient Surgical Procedures measure, beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. Lastly, we are proposing to adopt both the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults eCQM beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination, and the Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO–PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Hospital Outpatient Setting (THA/TKA PRO–PM), beginning with voluntary reporting in the CYs 2025 and 2026 reporting periods, followed by mandatory reporting beginning with the CY 2027 reporting period/CY 2030 payment determination.

Hospital OQR Program Forms

The Hospital OQR Program uses four administrative forms: (1) Extraordinary Circumstances Exception (ECE) Request; (2) Reconsideration Request; (3) Validation Review; and (4) Withdrawal of Participation Form. None of these forms are completed on an annual basis; all are

on a need-to-use, exception basis and most hospitals will not need to complete any of these forms in any given year. Thus, the burden for providers associated with forms utilized in the Hospital OQR Program is nominal, if any.

(1) Extraordinary Circumstances Exception (ECE) Request Form

In the event of extraordinary circumstances not within the control of the hospital, such as a natural disaster, a hospital can request an exception from meeting program requirements. This form can be found online and can be submitted electronically, by mail, or by fax. We note that the burden associated with completing and submitting an ECE request is accounted for in a separate PRA package, OMB control number 0938-1022 (expiration date January 31, 2026).[3] Therefore, the burden associated with completing and submitting and ECE Request is not addressed here.

(2) Reconsideration Request Form

When CMS determines that a hospital has not met program requirements and receives a 2.0 percentage point reduction in their APU, hospitals may submit a Reconsideration Request to CMS no later than the first business day on or after March 17 that is not a non-work day[4] of the affected payment year. CMS provides this form online and facilities may submit the form online or by fax. While there is burden associated with filing a Reconsideration Request, regulations under the Paperwork Reduction Act of 1995, 5 C.F.R. § 1320.4, exclude collection activities during the conduct of administrative actions such as reconsiderations. Therefore, the burden associated with submitting a Reconsideration Request is not accounted for in this PRA package.

[3] This burden is captured under another package because the hospital and ASC quality reporting and value-based purchasing programs use a single request form to avoid the use of multiple forms. Accounting for this burden under a single package ensures that all programs are using the same form, process, and burden estimates and avoids the risk of inconsistency or misalignment in CMS policies on this issue, as well as reducing inefficiencies in form updates and request processing.

[4] 42 CFR § 416.310(f) All deadlines occurring on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order are extended to the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order.

(3) Validation Review Form

CMS performs a random and targeted selection of OPPS hospitals on an annual basis. The selection includes up to 500 hospitals including 450 randomly selected hospitals and up to 50 targeted hospitals. In the event that CMS determines that a hospital did not meet the Hospital OQR Program validation requirement due to a confidence interval validation score of less than 75 percent, the hospital may complete and submit the Validation Review Form, which is submitted along with the Reconsideration Request Form.

In the CY 2023 OPPS/ASC final rule, we finalized that hospitals with less than four quarters of data subject to validation due to receiving an ECE for one or more quarters and with a two-tailed confidence interval that is less than 75 percent will be targeted for validation in the subsequent validation year (87 FR 72116). However, these hospitals will not be penalized for payment. Hospitals will still be subject to both payment penalization and targeting for the subsequent year if they either (a) have less than four quarters of data but do not have an ECE or waiver for one or more quarters and do not meet the 75 percent threshold; or (b) have four quarters of data subject to validation and do not meet the 75 percent threshold.

While there is burden associated with filing a Validation Review Form, regulations under the Paperwork Reduction Act of 1995, 5 C.F.R. § 1320.4, exclude collection activities during the conduct of administrative actions such as reconsiderations. Therefore, the burden associated with submitting a Validation Review Form is not accounted for in this PRA package.

(4) Withdrawal of Participation Form

Once a hospital submits quality measure data (e.g., using the web-based data collection tool), and the submission is accepted, it will continue to be considered a participant, regardless of whether it continues to submit quality measure data, until formally withdrawing from the program. To withdraw from the program after submitting quality measure data, a hospital must complete and submit an online withdrawal form by August 31st for the applicable CY. While there is burden associated with filing a Withdrawal of Participation Form, regulations under the Paperwork Reduction Act of 1995, 5 C.F.R. § 1320.4, exclude collection activities during the conduct of administrative actions. Therefore, the burden associated with submitting a Withdrawal of Participation Form is not accounted for in this PRA package.

2. Information Users

The Hospital OQR Program as a pay-for-reporting program strives to have a streamlined measure set that provides meaningful measurement that also serves to differentiate facilities by quality of care while limiting burden to the fullest extent possible. The measure information collected will be made available to hospitals for their use in internal quality improvement initiatives. This information is also available to Medicare beneficiaries, as well as to the general public, by providing hospital information on the *Care Compare* website to assist them in making decisions about their healthcare.

Additionally, QIN-QIOs use Hospital OQR Program data to improve quality of care through education, outreach, and sharing best practices. In addition, data collected for Fibrinolytic Therapy Received Within 30 Minutes measure (OP-2), the Median Time to Transfer to Another Facility for Acute Coronary Intervention measure (OP-3), Median Time to ED Discharge (OP-18), and Left Without Being Seen (OP-22) are included in the Medicare Beneficiary Quality Improvement Project (MBQIP), a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program of the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP). The goal of MBQIP is to improve the quality of care provided in critical access hospitals (CAHs) by increasing quality data reporting by CAHs and then driving quality improvement activities based on the data. The MBQIP provides an opportunity for individual hospitals to look at their own data, measure their outcomes against other CAHs and partner with other hospitals in the state around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients.[5] In the CY 2022 OPPS/ASC final rule, we finalized the removal of OP-2 and OP-3 effective with the CY 2023 reporting period/CY 2025 payment determination.

Also, under section 3014 of the Patient Protection and Affordable Care Act of 2010 (ACA), CMS is required to evaluate the impact and efficiency of CMS measures in quality reporting programs and to post the report every three years. Following the compilation of data from the Hospital OQR Program and other CMS programs, CMS' findings were formally written into the latest triennial National Impact Assessment Report, which was released in June 2021.[6]

3. Use of Information Technology

To assist hospitals successfully abstracting and submitting data for chart-abstracted measures, CMS employs the use of an established, free data collection tool, the CMS Abstraction and Reporting Tool (CART). CMS also provides a secure data warehouse via the Hospital Quality Reporting (HQR) system for storage and transmittal of data as well as data validation and aggregation services prior to the release of data to the CMS website. Hospitals have the option of using vendors to transmit the data. CMS has engaged a national support contractor to provide technical assistance with the data collection tool, other program requirements, and to provide education to support program participants. CMS continues to improve data collection tools in order to make data submission easier for hospitals (e.g., the automated collection of electronic patient data in EHRs for eCQMs and the collection of data from federal registries like the NHSN), as well as to increase the utility of the data provided by the hospitals.

As reflected by the collection and reporting of claims-based quality measures, quality measures submitted via the CMS web-based tool, and measures which are digitally-derived (e.g. eCQMs), efforts are made to reduce burden by limiting the adoption of measures requiring the submission of patient-level information that must be acquired through chart-abstraction and to employ

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

[6] The latest 2021 Impact Assessment Report, as well as earlier reports from 2012, 2015, and 2018 may be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/National-Impact-Assessment-of-the-Centers-for-Medicare-and-Medicaid-Services-CMS-Quality-Measures-Reports.

existing data and data collection systems. The complete list of measures and data collection forms are organized by type of data collected and data collection mechanism in Table 1.

4. Duplication of Efforts

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

5. Small Business

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

6. Less Frequent Collection

CMS has designed the collection of quality-of-care data to be the minimum necessary for data validation and calculation of summary figures to be reliable estimates of hospital performance. Under the Hospital OQR Program, hospitals are required to submit chart-abstracted measures to CMS on a quarterly basis and are required to submit eCQMs and web-based measures to CMS on an annual basis. Claims-based measures are calculated from Medicare FFS claims data; hospitals submit claims for reimbursement or payment per claims processing timeliness requirements. To collect the information less frequently would compromise the timeliness of any calculated estimates. In addition, the NHSN web-based measure collected by the CDC is submitted for at least one self-selected week during each month of the reporting quarter. To collect these measure data less frequently would compromise the timeliness of any calculated estimates.

7. Special Circumstances

All subsection (d) hospitals reimbursed under the OPPS must meet Hospital OQR Program requirements, including administrative, data submission, and validation requirements to receive the full APU for the given CY. Failure to meet all requirements may result in a 2.0 percentage point reduction in the APU.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice for this data collection was published on July 31, 2023 (88 FR 49552).

Measures adopted for the Hospital OQR Program are required by statute to undergo a recognized consensus process. Section 3014 of the ACA modified section 1890(b) of the Act to require CMS to develop quality and efficiency measures through a “consensus-based entity.” To fulfill this requirement, the Measure Applications Partnership (MAP) was formed to review measures

consistent with this provision of the Act. Beginning in CY 2023, the MAP will continue under a new name - the Partnership for Quality Measurement (PQM) - and will provide input on the Measures under Consideration (MUC) list as part of the Pre-Rulemaking Measure Review (PRMR). We refer readers to https://p4qm.org/PRMR-MSR for more information on the PRMR process. Prior and in addition to the ACA and the formation of the MAP or its predecessor, CMS has utilized consensus processes consistent with the authorizing statute for selecting and adopting quality measures for the Hospital OQR Program.

CMS is additionally supported in this program's efforts by the CDC, HRSA, and the Agency for Healthcare Research and Quality (AHRQ). These organizations consult with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making collected information accessible, understandable, and relevant to the public. CMS also regularly engages interested parties (e.g. solicitation of comments).

9. Payments/Gifts to Respondent

Hospitals are required to submit these data in order to receive the full APU. No other payments or gifts will be given to hospitals for participation.

10. Confidentiality

All information collected under the Hospital OQR Program will be maintained in strict accordance with statutes and regulations governing confidentiality requirements for CMS data, including the Privacy Act of 1974 (5 U.S.C. 552a), the Health Insurance Portability and Accountability Act (HIPAA), and the Quality Improvement Organizations confidentiality requirements, which can be found at 42 C.F.R. Part 480. Data related to the Hospital OQR Program is housed in the HQR application group. HQR is a General Support System (GSS) housing protected health information (PHI). Users who access the HQR system are identity-managed to permit access to the system and have role-based restrictions (including log-in and password) to the data they can see. The System of Records Notice (SORN) in use for the quality programs including the Hospital OQR Program is MBD 09-70-0536.

11. Sensitive Questions

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

12. Burden Estimate (Total Hours & Wages)

(a) Background

In the CY 2024 OPPS/ASC proposed rule, we are proposing to modify three previously adopted measures: (1) COVID–19 Vaccination Coverage Among HCP measure, beginning with the CY 2024 reporting period/CY 2026 payment determination; (2) Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure, beginning with the voluntary CY 2024 reporting period; and (3) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure, beginning with the CY 2024 reporting period/CY 2026 payment determination.

We are also proposing to adopt three new measures: (1) the Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO-PM), beginning with the voluntary CYs 2025 and 2026 reporting periods followed by mandatory reporting beginning with the CY 2027 reporting period/CY 2030 payment determination; (2) the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults eCQM, beginning with the voluntary CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; and (3) for re-adoption with modification, the Hospital Outpatient Volume on Selected Outpatient Surgical Procedures measure, with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.

Finally, we are proposing to remove the Patient Left Without Being Seen measure beginning with the CY 2024 reporting period/CY 2026 payment determination.

(b) Burden for the CY 2026 Payment Determination

For the Hospital OQR Program, the burden associated with meeting program requirements includes the time and effort associated with: (1) completing administrative requirements; (2) collecting and reporting data on the required measures under the Hospital OQR Program; and (3) submitting documentation for validation purposes.

For this proposed rule, based on data from the CY 2023 Hospital OQR Program payment determination, which supports this assumption, we will continue to estimate that 3,350 hospitals will report data to the Hospital OQR Program, unless otherwise noted. While the exact number of hospitals required to submit data annually may vary, we use this estimate to be consistent with previous rules and for ease of calculation across reporting periods.

We estimate that collecting and reporting data required under the Hospital OQR Program can be accomplished by staff with a median hourly wage of $52.12 per hour in accordance with the Bureau of Labor Statistics (BLS), based upon the median wage for Medical Records Specialists working in "general medical and surgical hospitals" which is $26.06 per hour before inclusion of overhead and fringe benefits.[7] BLS describes Medical Records Specialists as those who "compile, process, and maintain medical records of hospital and clinic patients in a manner

[7] In the CY 2023 OPPS/ASC final rule with comment period (87 FR 72250), we finalized an hourly wage estimate of $23.23 per hour, plus 100 percent overhead and fringe benefits. Since the CY 2023 OPPS/ASC final rule, BLS removed this labor category and added a new labor category titled "Medical Records Specialists." Wage rate information is available at: https://www.bls.gov/oes/current/oes292072.htm.

consistent with medical, administrative, ethical, legal, and regulatory requirements of the healthcare system;" therefore, we believe it is reasonable to assume that these individuals would be tasked with abstracting clinical data for submission for the Hospital OQR Program. We estimate the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage, as is currently done in other CMS quality reporting programs. This is necessarily a rough adjustment, because fringe benefits and overhead costs vary significantly from employer to employer. Nonetheless, we believe that doubling the hourly wage rate ($26.06 x 2 = $52.12) to estimate total cost is a reasonably accurate estimation method. Accordingly, we will use an hourly labor cost estimate of $52.12 ($26.06 salary plus $26.06 fringe and overhead) for calculation of burden forthwith.

(1) Administrative Burden

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

As previously noted in Section B(3), the Hospital OQR Program utilizes four forms in its administrative activities: (1) Extraordinary Circumstances Exception (ECE) Request; (2) Reconsideration Request; (3) Validation Review; and (4) Withdrawal from Participation Form. None of these forms are completed on an annual basis; all are on a need-to-use, exception basis and most hospitals will not need to complete any of these forms in any given year. Thus, the burden associated with forms utilized in the Hospital OQR Program is nominal, if any.

The burden associated with submitting an ECE Request is accounted for in OMB control number 0938-1022 (expiration date January 31, 2026) and is therefore excluded from this burden estimate. Moreover, consistent with regulations under the Paperwork Reduction Act of 1995, 5 C.F.R. § 1320.4, the burden associated with filing a Reconsideration Request, Validation, or a Withdrawal from Participation Form is excluded from this package because this collection occurs during the conduct of an administrative action.

In the CY 2024 OPPS/ASC proposed rule, we are not proposing any changes to the administrative burden for the CY 2025 payment determination. Thus, our estimates for administrative burden remain the same as those previously approved for the CY 2024 payment determination under this OMB control number. Specifically, we previously estimated, in the CY 2014 OPPS/ASC final rule with comment period (78 FR 75171), that the burden associated with completing administrative requirements is 42 hours per hospital. Therefore, for all participating hospitals, we estimate a total annual administrative burden of 140,700 hours (42 hours per hospital x 3,350 hospitals) and a total financial burden of $7,333,284 (140,700 hours x $52.12 per hour).

(2) Chart-Abstraction Burden

For the CY 2026 payment determination, the chart-abstracted measure set for the Hospital OQR Program is comprised of the Median Time for Discharged ED Patients and the Head CT or MRI

Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of emergency department Arrival measures.

For chart-abstracted measures where patient-level data are submitted directly to CMS, we previously estimated it would take 2.9 minutes, or 0.049 hours per case per measure to collect and submit the data for each submitted case (80 FR 70582). Additionally, we estimate that an average of 289 cases are reported per hospital for chart-abstracted measures. We therefore estimate that it will take approximately 14.2 hours (0.049 hours x 289 cases) at a cost of approximately $738 per hospital (14.2 hours x $52.12/hour) to collect and report data for each chart-abstracted measure. Therefore, for all participating hospitals, we estimate an annual chart-abstraction burden of 47,570 hours (14.2 hours per hospital x 3,350 hospitals) at a cost of $2,479,348 per measure (47,570 hours x $52.12/hour). For the CY 2026 payment determination and subsequent years, the total annual burden for all hospitals to submit both measures are estimated to be 95,140 hours (47,570 hours/measure x 2 measures) at a cost $4,958,697 (95,140 hours x $52.12/hour).

(3) Web-Based Measures Burden

There are four web-based measures in the Hospital OQR Program for the CY 2025 payment determination and subsequent years: Patient Left Without Being Seen, Colonoscopy Follow-Up Interval, Cataracts Visual Function, and COVID-19 Vaccination Among HCP.

In the CY 2024 OPPS/ASC proposed rule, we are proposing to modify the Colonoscopy Follow-Up Interval measure to amend the measure denominator language by removing the phrase “aged 50 years” and adding in its place the phrase “aged 45 years”. We are also proposing to modify the Cataracts Visual Function measure to limit the visual function surveys that can be used to administer this measure to three assessment tools: NEI VFQ-25, VF-14, and VF-8R, beginning with the voluntary CY 2024 reporting period. We are not proposing an increase in the required sample size for chart abstraction for either measure; therefore, we do not believe there is any increase in burden associated with these proposals. We are also proposing to modify the COVID-19 Vaccination Among HCP measure to utilize the term “up to date” in the HCP vaccination definition, as well as to update the numerator to specify the timeframes within which an HCP is considered up to date with CDC recommended COVID–19 vaccines, including booster doses, beginning with the CY 2024 reporting period/CY 2026 payment determination. We are also proposing in the CY 2024 OPPS/ASC proposed rule to remove the Patient Left Without Being Seen measure beginning with the CY 2024 reporting period/CY 2026 payment determination.

- We previously estimated in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70582), that hospitals spend approximately 10 minutes, or 0.167 hours, per measure to report web-based measures.

  For the CY 2026 payment determination, we estimate a web-based burden of 558.3 hours (0.1667 hours/hospital x 3,350 hospitals) at a cost of $29,100 (558.3 hours x $52.12/hour) for one measure. For the CY 2027 payment determination and subsequent years, we estimate a web-based burden of 670 hours [(0.1667 hours/hospital x 3,350 hospitals) +

(0.1667 hours/hospital x 3,350 hospitals x 20% x 1 measure)] at a cost of $34,920 (670 hours x $52.12/hour) for two measures.

- There are two web-based measures in the Hospital OQR Program measure set that also require chart-abstraction: Colonoscopy Follow-Up Interval and Cataracts Visual Function.

  We previously estimated that chart abstraction for a web-based measure requires 2.9 minutes, or 0.049 hours, per case per measure as finalized in the CY 2016 OPPS/ASC final rule (80 FR 70582), and that hospitals would abstract an average of 242 cases per year for this measure. Upon review, the use of this average number of cases was incorrect. Based on the current Hospital OQR Program Specifications Manual, the sample size requirement for hospitals with populations of 900 patients or less is 63 cases annually and the requirements for hospitals with populations of greater than 900 patients is 96 cases annually.[8] To be conservative, we will base our burden estimates on an estimate of 96 cases per hospital annually.

  For the CY 2026 payment determination, we estimate a chart-abstraction burden of 15,758 hours [(0.049 hours/case x 96 cases/measure x 3,350 hospitals x 1 measure) at a cost of $821,307 (15,758 hours x $52.12/hour) for one measure. For the CY 2027 payment determination and subsequent years, we estimate a chart-abstraction burden of 18,910 hours [(0.049 hours/case x 96 cases/measure x 3,350 hospitals x 1 measure) + (0.049 hours/case x 96 cases/measure x 3,350 hospitals x 20% x 1 measure)] at a cost of $985,589 (18,910 hours x $52.12/hour) for both measures.

In the CY 2024 OPPS/ASC proposed rule, we are proposing to re-adopt with modification the Hospital Outpatient Volume on Selected Outpatient Surgical Procedures measure, beginning with the voluntary CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. This measure was previously finalized in the CY 2012 OPPS/ASC final rule with the assumption that, because hospitals must determine their populations for data reporting purposes - and most hospitals are voluntarily reporting population and sampling data for Hospital OQR Program purposes - the only additional burden would be the reporting of the data using a web-based tool (now the HQR system) (76 FR 74552 through 74553). We believe this assumption continues to be applicable and estimate the burden consistent with both the CY 2012 OPPS/ASC final rule when the measure was initially adopted (76 FR 74552) as well as the CY 2018 OPPS/ASC final rule when the measure was previously removed (82 FR 52618). We estimate that each participating hospital would spend 10 minutes per year to collect and submit the data for this measure. For the voluntary CY 2025 reporting period, we assume 20 percent of hospitals would report data, resulting in an annual burden of 111.7 hours (3,350 hospitals x 20 percent x 0.167 hours) at a cost of $5,822 (111.7 hours x $52.12/hour) for voluntarily participating hospitals. For mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination, we estimate an annual burden of 558.3 hours (3,350 hospitals × 0.167 hours) at a cost of $29,100 (558.3 hours × $52.12/hour).

[8] https://qualitynet.cms.gov/outpatient/specifications-manuals

For all participating hospitals for the CY 2026 payment determination, we estimate a burden of 16,316 hours (558.3 hours for web-based burden and 15,758 hours for chart-abstraction) at a cost of $850,407 (16,316 hours x $52.12/hour). For the CY 2027 payment determination, we estimate a burden of 19,692 hours (782 hours for web-based burden and 18,910 hours for chart-abstraction) at a cost of $1,026,331 (19,692 hours x $52.12/hour). For the CY 2028 payment determination and subsequent years, we estimate a burden of 20,138 hours (1,228.3 hours for web-based burden and 18,910 hours for chart-abstraction) at a cost of $1,049,609 (20,138 hours x $52.12/hour).

(4) Claims-Based Measures Burden

Claims-based measures are derived through analysis of administrative claims data and do not require additional effort or burden on hospitals. As a result, the Hospital OQR Program's claims-based measures (see Table 1) do not influence our burden calculations.

(5) Survey Measures Burden

The information collection requirements associated with the five OAS CAHPS survey-based measures are currently approved under OMB control number 0938-1240, which expires November 30, 2024. As a result, the policy to require data collection for these measures does not influence our burden calculations.

(6) eCQM Measures Burden

In the CY 2022 OPPS/ASC final rule, we finalized the adoption of the STEMI eCQM, with voluntary reporting beginning with the CY 2023 reporting period/CY 2025 payment determination and mandatory reporting beginning with the CY 2024 reporting period/CY 2026 payment determination. For the CY 2023 voluntary reporting period, hospitals are able to voluntarily report the measure for one or more quarters during the year. In subsequent years, we finalized gradually increasing the number of quarters of data hospitals are required to report on the measure starting with one self-selected quarter for the CY 2024 reporting period/CY 2026 payment determination, two self-selected quarters for the CY 2025 reporting period/CY 2027 payment determination, three self-selected quarters for the CY 2026 reporting period/CY 2028 payment determination, and four quarters for the CY 2027 reporting period/CY 2029 payment determination and for subsequent years.

For the voluntary reporting period in CY 2023, we estimate 20 percent of hospitals would report at least one quarter of data for the measure with 100 percent of hospitals reporting the measure as required in subsequent years. Based on experience with reporting of eCQMs in the Hospital Inpatient Quality Reporting (IQR) Program, we are aligning our estimate of the time required for a Medical Records Specialist to submit the data required for the measure to be 10 minutes (0.1667 hours) per quarter for each hospital. For the CY 2023 voluntary reporting period, we estimate an annual burden for voluntarily participating hospitals of 112 hours (3,350 hospitals x 20% x 0.1667 hours x 1 quarter) at a cost of $5,822 (112 hours x $52.12/hour). For the CY 2024 reporting period/CY 2026 payment determination, we estimate the annual burden for all hospitals to be 558 hours (3,350 hospitals x

0.1667 hours x 1 quarters) at a cost of $29,099 (558 hours x $52.12/hour). For the CY 2025 reporting period/CY 2027 payment determination, we estimate the annual burden for all hospitals to be 1,117 hours (3,350 hospitals x 0.1667 hours x 2 quarters) at a cost of $58,202 (1,117 hours x $52.12/hour). For the CY 2026 reporting period/CY 2028 payment determination, we estimate the annual burden for all hospitals to be 1,675 hours (3,350 hospitals x 0.1667 hours x 3 quarters) at a cost of $87,031 (1,675 hours x $52.12/hour). For the CY 2027 reporting period/CY 2029 payment determination and subsequent years, we estimate the annual burden for all hospitals to be 2,233 hours (3,350 hospitals x 0.1667 hours x 4 quarters) at a cost of $116,400 (2,233 hours x $52.12/hour).

In the CY 2024 OPPS/ASC proposed rule, we are proposing to adopt the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults eCQM, beginning with the voluntary CY 2025 reporting period, followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. For the CY 2025 voluntary reporting period, hospitals would be able to voluntarily report the measure for one or more quarters during the year. For subsequent years, we propose to gradually increase the number of quarters of data hospitals would be required to report on the measure starting with two self-selected quarters for the CY 2026 reporting period/CY 2028 payment determination, and all four quarters for the CY 2027 reporting period/CY 2029 payment determination.

For the voluntary reporting period in CY 2025, we estimate 20 percent of hospitals would voluntarily report at least one quarter of data for the measure with 100 percent of hospitals reporting the measure as proposed to be required in subsequent years. Similar to the STEMI eCQM, we assume a Medical Records Specialist would require 10 minutes to submit the data required per quarter for each hospital. For the CY 2025 voluntary reporting period, we estimate an annual burden for voluntarily participating hospitals of 112 hours (3,350 hospitals × 20 percent × 0.1667 hours × 1 quarter) at a cost of $5,822 (112 hours × $52.12/hour). For the CY 2026 reporting period/CY 2028 payment determination, we estimate the annual burden for all participating hospitals to be 1,117 hours (3,350 hospitals × .1667 hours × 2 quarters) at a cost of $58,202 (1,117 hours × $52.12/hour). For the CY 2027 reporting period/CY 2029 payment determination, we estimate the annual burden for all participating hospitals to be 2,233 hours (3,350 hospitals × .1667 hours × 4 quarters) at a cost of $116,400 (2,233 hours × $52.12/hour).

(7) Patient-Reported Outcome Measures

In the CY 2024 OPPS/ASC proposed rule, we are proposing to adopt the THA/TKA PRO-PM beginning with voluntary CYs 2025 and 2026 reporting periods, followed by mandatory reporting beginning with the CY 2027 reporting period/CY 2030 payment determination. This measure was previously adopted for the Hospital IQR Program in the FY 2023 IPPS/LTCH PPS final rule with an estimated burden of 7.25 minutes (0.120833 hours) per patient to complete both the pre-operative and post-operative surveys and 10 minutes (0.167 hours) per hospital per response to collect and submit the measure data via the HQR system (87 FR 49386 through 49387). We believe the estimated burden for both patient surveys and data submission would be the same for the Hospital OQR Program.

The THA/TKA PRO–PM uses four sources of data for the calculation of the measure: (1) patient-reported outcome (PRO) data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. We estimate no additional burden associated with claims data, Medicare enrollment and beneficiary data, and U.S. Census Bureau survey data as these data are already collected via other mechanisms such as Medicare enrollment forms, CMS Form 1500, and U.S. Census Informational Questionnaires. Many hospitals have already incorporated patient-reported outcome (PRO) data collection into their workflows. While we are not proposing to require how hospitals collect PRO data for this measure, hospitals new to collecting PRO data would have multiple options for when and how they would collect these data so they could best determine the mode and timing of collection that works best for their patient population.

The possible patient touchpoints for pre-operative PRO data collection include the doctor's office, pre-surgical steps such as education classes, or medical evaluations that can occur in an office or at the hospital. The modes of PRO data collection could include completion of the pre-operative surveys using electronic devices (such as an iPad or tablet), pen and paper, mail, telephone, or through a patient portal. Post-operative PRO data collection modes are similar to pre-operative modes. The possible patient touchpoints for post-operative data collection can occur before the follow-up appointment, at the doctor's office, or after the follow-up appointment. The potential modes of PRO data collection for post-operative data are the same as for pre-operative data. If the patient does not or cannot attend a follow-up appointment, the modes of collection could include completion of the post-operative survey using email, mail, telephone, or through a patient portal. Similar to other surveys, like the OAS CAHPS, we believe the use of multiple modes would maximize response rates as it allows for different patient preferences.

For the THA/TKA PRO–PM data, hospitals would be able to submit data during two voluntary periods. The first voluntary reporting period would begin in CY 2025 for eligible procedures occurring between January 1, 2025, through December 31, 2025, and the second voluntary reporting period would begin with CY 2026 for eligible procedures occurring between January 1, 2026, through December 31, 2026. Voluntary reporting would be followed by mandatory reporting for eligible elective procedures beginning with the CY 2027 reporting period (occurring January 1, 2027, through December 31, 2027), impacting the CY 2030 payment determination. Hospitals would need to submit data twice (pre-operative data and post-operative data).

For the purposes of calculating burden, similar to assumptions used for the Hospital IQR Program in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49386 through 49387), we estimate that during the voluntary periods, 50 percent of hospitals that perform at least one THA/TKA procedure would submit data for 50 percent of THA/TKA patients. For purposes of calculating burden, we estimate that, during the mandatory period, hospitals would submit for 100 percent of patients. While we propose to require hospitals to submit, at minimum, 50 percent of eligible, complete pre-operative data with matching eligible, complete post-operative data, we are conservative in our estimate for the mandatory period in case hospitals exceed this threshold.

To estimate the cost burden for patients completing the surveys for this proposed measure, we refer to the "Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices,"[9] as it identifies the approach for valuing time when individuals undertake activities on their own time. Therefore, we estimate that the cost for beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $20.71/hour. To derive the costs for beneficiaries, a measurement of the usual weekly earnings of wage and salary workers of $998, divided by 40 hours to calculate an hourly pre-tax wage rate of $24.95/hour. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in the post-tax hourly wage rate of $20.71/hour. Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

For burden estimating purposes for this proposed measure, we assume that most hospitals would likely undertake PRO data collection through a screening tool incorporated into their EHR or other patient intake process. We estimate that approximately 526,793 THA/TKA procedures occur in the outpatient setting each year, and that many patients could complete both the pre-operative and post-operative questionnaires. However, from our experience with using this measure in the Comprehensive Joint Replacement model, we are also aware that not all patients who complete the pre-operative questionnaire would complete the post-operative questionnaire. For CYs 2025 and 2026 voluntary reporting periods, we assume 50 percent of patients from 50 percent of the hospitals, or 131,698 patients, would complete the survey (526,793 patients × 0.50 × 0.50 of hospitals) for a total of 15,914 hours annually (131,698 respondents × 0.120833 hours) at a cost of $329,579 (15,914 hours × $20.71/hour). Beginning with mandatory reporting in the CY 2027 reporting period, we estimate a total of 63,654 hours (526,793 patients × 0.120833 hours) at a cost of $1,318,274 (63,654 hours × $20.71/hour) across all hospitals.

Regarding hospitals' burden related to submitting data for this proposed measure, which would be reported via the HQR System, we estimate a burden of 10 minutes per response. Hospitals would submit data associated with pre-operative surveys by March 31 of the CY following the CY in which the eligible procedures took place and would submit data associated with post-operative surveys by March 31 of the CY following the CY in which pre-operative data were submitted. Therefore, for the first voluntary reporting period for eligible procedures occurring in CY 2025, pre-operative survey data submission would occur in the first quarter of the CY 2026 reporting period and post-operative survey data submission would occur in the first quarter of the CY 2027 reporting period. For each reporting period, we estimate that each hospital would spend 20 minutes (0.33 hours) annually (10 minutes × 2 surveys) to collect and submit the data. For the voluntary CY 2026 reporting period, we estimate a burden for 50 percent of participating hospitals of 279.2 hours (0.167 hours × 3,350 hospitals × 50 percent) at a cost of $14,552 (279.2 hours × $52.12/hour). For the voluntary CY 2027 reporting period, we estimate a burden for 50 percent of participating hospitals of 558.3 hours (0.33 hours × 3,350 hospitals × 50 percent) at a cost of $29,099 (558.3 hours × $52.12/hour). For the mandatory CY 2028 reporting period, we estimate a burden for all participating hospitals of 837.5 hours [(0.167 hours × 3,350 hospitals × 50 percent) + (0.167 hours x 3,350 hospitals)] at a cost of $43,651 (837.5 hours × $52.12/hour).

[9] This report is available at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//176806/VOT.pdf.

For the mandatory CY 2029 reporting period and subsequent years, we estimate a total of 1,116.7 hours (0.33 hours × 3,350 hospitals) at a cost of $58,202 (1,116.7 hours × $52.12/hour).

(8) Validation Burden

The burden associated with the validation procedures is the time and effort necessary to submit supporting medical record documentation for validation. We previously estimated that it would take each of the 500 selected hospitals approximately 12 hours to comply with these data submission requirements (76 FR 74553, 74577). To comply with the requirements, we also estimated that each hospital would submit up to 48 cases for the affected year for review (76 FR 74553).

Because all selected hospitals must comply with these requirements each year, we continue to estimate a total submission of up to 24,000 charts by the selected hospitals (500 hospitals × 48 cases per hospital) (76 FR 74553). Therefore, for the selected hospitals, we continue to estimate a total annual validation burden, for four quarters of data, of 6,000 hours (500 hospitals x 12 hours per hospital), and a total financial burden of approximately $312,720 (6,000 hours x $52.12/hour).

As discussed above, in the CY 2023 OPPS/ASC final rule, we finalized that hospitals with less than four quarters of data subject to validation due to receiving an ECE for one or more quarters and with a two-tailed confidence interval that is less than 75 percent will be targeted for validation in the subsequent validation year. However, these hospitals will not be penalized for payment. Hospitals will still be subject to both payment penalization and targeting for the subsequent year if they either (a) have less than four quarters of data but do not have an ECE or waiver for one or more quarters and do not meet the 75 percent threshold; or (b) have four quarters of data subject to validation and do not meet the 75 percent threshold. This policy does not increase reporting burden, because it changes neither the total number of hospitals required to submit data nor the amount of data hospitals selected for validation would be required to submit.

(9) Total Burden for the CY 2026 through CY 2029 Payment Determinations

Based on the preceding discussion, the tables below summarize our calculations of burden for the CY 2026 through CY 2029 payment determinations.

Table 2. Total Burden Hours for the CY 2026 through CY 2029 Payment Determinations

Information Collection	CY 2026	Difference from Currently Approved	CY 2027	Difference from Currently Approved	CY 2028	Difference from Currently Approved	CY 2029	Difference from Currently Approved
Administrative Activities	140,700	0	140,700	0	140,700	0	140,700	0
Chart-Abstracted Measures	95,140	0	95,140	0	95,140	0	95,140	0
Web-Based Measures	16,316	-32,582	19,692	-29,206	20,138	-28,760	20,138	-28,760
Claims-Based Measures	N/A	0	N/A	0	N/A	0	N/A	0
Survey-Based Measures	N/A	0	N/A	0	N/A	0	N/A	0
eCQM Measures	558	0	1229	+112	2,792	+1,117	4,467	+2,233
PRO-PM	0	0	15,914	+15,914	16,193	+16,193	64,212	+64,212
Validation	6,000	0	6,000		6,000	0	6,000	0
TOTAL	**258,714**	**-32,582**	**278,675**	**-13,180**	**280,963**	**-11,450**	**330,657**	**37,685**

Table 3. Total Burden Dollars for the CY 2026 through CY 2029 Payment Determinations*

Information Collection	CY 2026	Difference from Currently Approved	CY 2027	Difference from Currently Approved	CY 2028	Difference from Currently Approved	CY 2029	Difference from Currently Approved
Administrative Activities	$7,333,284	+$796,362	$7,333,284	+$796,362	$7,333,284	+$796,362	$7,333,284	+$796,362
Chart-Abstracted Measures	$4,958,697	+$538,493	$4,958,697	+$538,493	$4,958,697	+$538,493	$4,958,697	+$538,493
Web-Based Measures	$850,407	-$1,421,394	$1,026,331	-$1,245,470	$1,049,609	-$1,222,192	$1,049,609	-$1,222,192
Claims-Based Measures	N/A	0	N/A	0	N/A	0	N/A	0
Survey-Based Measures	N/A	0	N/A	0	N/A	0	N/A	0
eCQM Measures	$29,099	+$3,159	$64,024	+$12,144	$145,233	+$67,412	$232,800	+$116,400
PRO-PM	0	0	$329,579	+$329,579	$344,131	+$344,131	$1,347,373	+$1,347,373
Validation	$312,720	+$33,960	$312,720	+$33,960	$312,720	+$33,960	$312,720	+$312,720
TOTAL	**$13,484,207**	**-$49,420**	**$14,024,635**	**$465,068**	**$14,143,674**	**$558,166**	**$15,234,483**	**$1,889,156**

*Dollar amounts may vary slightly due to rounding

13. Capital Costs (Maintenance of Capital Costs)

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

For hospitals that are not currently collecting Hospital-Level THA/TKA PRO-PM data, there would be some non-recurring costs associated with changes in workflow and information systems to collect the data. The extent of these costs is difficult to quantify as different hospitals may utilize different modes of data collection (for example, paper-based, electronically patient-directed, clinician-facilitated, etc.). While we assume the majority of hospitals would report data for this measure via the HQR System, we assume some hospitals may elect to submit measure data via a third-party vendor, for which there are associated costs. Under OMB control number 0938-0981 for the HCAHPS Survey measure (expiration date September 30, 2024), an estimate of approximately $4,000 per hospital is used to account for these costs. This estimate originates from 2012, therefore, to account for inflation (assuming end of CY 2012 to April 2023), we adjust the price using the Bureau of Labor Statistics Consumer Price Index and estimate an updated cost of approximately $5,284 ($4,000 x 132.1 percent).[10]

14. Cost to Federal Government

The cost to the Federal Government for maintaining program activities is for supporting data system architecture, data storage, maintenance and updating of information technology infrastructure on the HQR system secure portal, providing ongoing technical assistance to hospital and data vendors, calculation of claims-based measures and validation, measure development and maintenance, the provision of hospitals with feedback and preview reports, as well as costs associated with public reporting. These costs are estimated at $10,050,000 annually. Additionally, this program takes one CMS staff at a GS-13 Step 5 level to operate. GS-13 Step 5 approximate annual salary is $126,949 plus benefits (30%) of $38,085 for a total cost of $168,034.

For most of 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.

The total annual cost to the Federal Government is $10,218,034.

15. Program or Burden Changes

[10] U.S. Bureau of Labor Statistics. Historical CPI-U data. Accessed on March 9, 2023. Available at: https://www.bls.gov/cpi/tables/supplemental-files/historical-cpi-u-202304.pdf

The proposed readoption of the Hospital Outpatient Volume on Selected Outpatient Surgical Procedures measure would result in a total burden increase of 558.3 hours at a cost of $29,100 through the CY 2029 payment determination.

The proposed adoption of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults eCQM would result in a total burden increase of 2,233 hours at a cost of $116,400 through the CY 2029 payment determination.

The proposed adoption of the THA/TKA PRO-PM would result in a total burden increase of 64,771 hours at a cost of +$1,347,373through the CY 2029 payment determination.

The proposed removal of the Patient Left Without Being Seen measure would result in a total burden decrease of -558.3 hours at a cost of -$29,100.

In addition, we updated our burden estimates for the Colonoscopy Follow-Up Interval and Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery web-based measures to account for the correct sample sizes. This correction results in a decrease in burden of -28,759 hours at a cost of -$1,498,919 through the CY 2027 payment determination.

In aggregate, we estimate the corrections to previous calculations as well as policies and updated assumptions proposed in the CY 2024 OPPS/ASC proposed rule would result in a total net increase of 38,245 hours (558.3 + 2,233 + 64,771 – 558.3 – 28,759) at a net cost of -$6,043 ($29,100 + $116,400 + $1,376,476 - $29,100 - $1,498,919) through the CY 2031 payment determination.

We are also updating the wage rate from $46.46/hour to $52.12/hour based on more recent BLS wage data, as previously discussed. This increase of $5.66/hour results in a total increase in burden of $1,464,321 (258,714 hours x $5.66) for the estimated burden hours for the CY 2026 payment determination.

For the CY 2024 reporting period/CY 2026 payment determination, based on the proposals in the CY 2024 OPPS/ASC proposed rule, we estimate a total burden of 258,714 hours and $13,484,207 (a decrease of 32,582 hours and $49,420 from our estimate in the CY 2023 OPPS/ASC final rule). However, this burden estimate also represents a decrease of 32,136 hours and $28,668 from the currently approved burden estimate of 290,850 hours and $13,512,875 for the CY 2023 reporting period/CY 2025 payment determination.

16. Publication

The goal of the data collection is to tabulate and publish hospital specific data. CMS will continue to display information on the quality of care provided in the hospital outpatient setting for public viewing as required by MIEA-TRHCA. Data from this initiative are currently used to populate the *Care Compare* and data.cms.gov websites. We anticipate updating these data on at least a quarterly basis.

17. Expiration Date

CMS will display the expiration date on the collection instruments.

18. Certification Statement

There are no exceptions to the certification statement.

19. Collections of Information Employing Statistical Methods

This information collection does not require the use of statistical methods. However, to reduce burden, facilities may sample using either the simple random sampling or systematic random sampling method applied consistently within a quarter to reduce the number of cases for which to submit data for certain measures.