Supporting Statement—Part A

Submission of Information for the Hospital-Acquired Condition (HAC) Reduction Program: FY 2025 IPPS/LTCH Final Rule (OMB #0938-1352, CMS-10668)

A. Background

This is a revision of the currently approved information collection request. 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 empower Medicare beneficiaries and inform decision-making, as well as to incentivize healthcare facilities to make continued improvements.

Specifically, CMS has implemented quality measure reporting programs for multiple 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 information collection requirements through the FY 2025 program year are currently approved under OMB control number 0938-1352 (expiration date November 30, 2025). This request covers data collection requirements for the FY 2025 program year and subsequent years. This revised information collection request includes burden for the Measure Exception Form for NHSN HAI Data Submission previously included under OMB control number 0938-1022.

B. Justification

1. Need and Legal Basis

The HAC Reduction Program is established by section 1886(p) of the Social Security Act, as added by Section 3008 of the Affordable Care Act (Pub. L. 111-148), and requires the Secretary to reduce payments to subsection (d) hospitals in the worst-performing quartile of all subsection (d) hospitals by 1 percent effective beginning on October 1, 2014 and subsequent years.

The HAC Reduction Program identifies the worst-performing quartile of hospitals by calculating a Total HAC Score derived from the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) and National Healthcare Safety Network (NHSN) Healthcare-associated Infection (HAI) measures, which require that we collect claims-based and chart-abstracted measures data, respectively. The HAC Reduction Program validates NHSN HAI data reported by subsection (d) hospitals to ensure that hospitals report correct NHSN HAI measure data, and the Total HAC Score is calculated using accurate data. The HAC Reduction Program may penalize any hospitals that fail

validation by assigning the maximum Winsorized *z*-score for the set of measures that fail validation, for use in the Total HAC Score calculation. The collection of information for validation is necessary to ensure that the HAC Reduction Program and Total HAC Score are administered fairly.

(a) HAC Reduction Program Measures

The HAC Reduction Program must collect information to verify hospital exceptions and data submissions. To reduce burden, a variety of different data collection mechanisms are employed, with every consideration taken to employ data and data collection systems already in place. The HAC Reduction Program relies on data collection for HAI measures established through the Centers for Disease Control and Prevention (CDC) under OMB control number 0920-0666 (expiration date December 31, 2026), and validation processes established through the Hospital Inpatient Quality Reporting (IQR) Program under OMB control number 0938-1022 (expiration date January 31, 2026). However, in the FY 2019 IPPS/LTCH PPS final rule, the Hospital IQR Program finalized the removal of the CDC NHSN HAI measures and NHSN HAI validation processes beginning on January 1, 2020. To continue validation of these measures, the HAC Reduction Program adopted validation templates similar to the ones previously used under the Hospital IQR Program. These templates continue the HAC Reduction Program's use and validation of NHSN HAI data.

The HAC Reduction Program currently has adopted six measures finalized in previous rulemaking, shown in Table 1.

Table 1. Currently Approved HAC Reduction Program Measures for the FY 2025 Program Year

Measure Data Submission Mode and Name	CBE No.
Claims-Based Measures	
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	0531
NHSN NAI Measures	
CDC NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDC NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716

Because the burden associated with submitting data for the HAI measures shown in Table 1 is captured under OMB control number 0920-0666, we do not provide an independent estimate of the burden associated with collecting data for these measures for the HAC Reduction Program. We

also do not provide an estimate of burden for the claims-based PSI 90 measure, because this measure is collected using Medicare Fee-for-Service (FFS) claims that hospitals are already submitting to the Medicare program for payment purposes. Similarly, we do not provide an estimate of burden for validation of data submitted for the PSI 90 measure, because Medicare claims are audited under the Medicare FFS Recovery Audit Program.

The FY 2025 program year for the HAC Reduction Program will be based on data for the CMS PSI 90 measure using the 24-month period from July 1, 2021 through June 30, 2023, and data for NHSN HAI measures using the 24-month period from January 1, 2022 through December 31, 2023, which are consistent with the applicable periods specified at 42 CFR § 412.170. Because the HAC Reduction Program is a payment program, it must ensure proper exceptions are available to hospitals that do not meet NHSN HAI data requirements and to ensure the accuracy of the NHSN HAI data submissions.

(b) HAC Reduction Program Administrative Forms

CMS has implemented procedural requirements that align the current quality reporting programs, including the HAC Reduction, PPS-Cancer Hospital Quality Reporting (PCHQR), Hospital IQR, Hospital Readmissions Reduction, Hospital Outpatient Quality Reporting, and Hospital Value-Based Purchasing (VBP) Programs. These procedural requirements involve submission of forms to comply with the HAC Reduction Program requirements.

The HAC Reduction Program uses five administrative forms: (1) Data Accuracy and Completeness Acknowledgement (DACA) Form; (2) Measure Exception Form for NHSN HAI Data Submission; (3) Validation Educational Review Form; (4) Validation Review for Reconsideration Request Form; and (5) Extraordinary Circumstances Exceptions (ECE) Request Form. We discuss validation templates in section B.12.d. The DACA, Validation Education Review Form and ECE Request Form are used across ten quality programs (Hospital IQR Program, Hospital Outpatient Quality Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, PCHQR Program, Ambulatory Surgical Center Quality Reporting Program, Hospital VBP Program, HAC Reduction Program, Hospital Readmissions Reduction Program, End Stage Renal Disease Quality Incentive Program, and Skilled Nursing Facility VBP Program), therefore we have included the burden associated with these forms under OMB control number 0938-1022 (Hospital IQR Program). Most of these administrative forms are not completed on an annual basis, but 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 HAC Reduction Program is nominal, if any.

a. DACA Form

Annually, hospitals participating in hospital quality reporting use the Hospital Quality Reporting DACA form after the end of each reporting year. This requirement was added based on a U.S. Government Accountability Office report from 2006 that recommended that CMS require hospitals to "formally attest to the completeness of the quality data that they submit." This form, completed annually, is an acknowledgement that the data a hospital has submitted are complete and accurate.

b. Measure Exception Form for NHSN HAI Data Submission

Hospitals that do not treat specified conditions or that do not have treatment locations defined for certain NHSN's HAI measures (CLABSI, CAUTI, and Surgical Site Infection) have the option to either complete the enrollment process with NHSN and indicate that they do not have patients who meet the measure requirements or submit a Measure Exception Form for NHSN HAI Data Submission. This Measure Exception Form reduces the burden of completing the entire NHSN enrollment process or entering zero denominator information for inapplicable measures for the hospitals that meet the exception requirements.

c. Validation Educational Review Form

Hospitals may use the educational review process to correct disputed chart-abstracted HAI-measure validation results. To submit a formal request, hospitals can utilize the Validation Educational Review Form. We note that should the results of an educational review not be favorable to a hospital, a hospital may still also request reconsideration of those results using the Validation Review for Reconsideration Request Form.

d. Validation Review for Reconsideration Request Form

If CMS determines that a hospital failed validation and the hospital would like to request a reconsideration, the hospital must complete and submit this form and if desired, may submit a copy of the entire medical record for the appealed element(s).

e. ECE Request Form

CMS offers a process for hospitals to request exceptions to the reporting of required data, for one or more quarters when a hospital experiences an extraordinary circumstance beyond the hospital's control. The ECE Request Form indicates that the request must be submitted within 90 calendar days of an extraordinary circumstance event for all programs.

2. Information Users

CMS will use the information collected for the HAC Reduction Program to determine whether a hospital is within the penalty quartile of subsection (d) hospitals. As stated above, the HAC Reduction Program applies a 1-percent payment reduction or penalty to subsection (d) hospitals in the worst-performing quartile of all subsection (d) hospitals. To determine which hospitals are in the worst-performing quartile, the HAC Reduction Program uses CMS PSI 90 data and NHSN HAI measure data. The Program must collect chart-abstracted information to validate NHSN HAI data reported by subsection (d) hospitals to ensure that hospitals report correct NHSN HAI measure data, and the Total HAC Score is calculated using accurate data. The information will be made available publicly and confidentially for hospitals to 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 and to assist them in making decisions about their healthcare. CMS sometimes conducts focus groups or market testing prior to publicly reporting hospital quality data on the Compare tool hosted by HHS or its successor

website(s) to get feedback on ways to make the website more user-friendly. Feedback from these focus groups has helped CMS understand how beneficiaries and consumers use the Compare tool hosted by HHS or its successor website(s).

3. Use of Information Technology

To assist hospitals in participating in standardized data collection initiatives across the industry, CMS continues to improve data collection tools with the goal of making data submission easier (including the free CMS Abstraction and Reporting Tool (CART) for use in collecting data from paper or electronic medical records for chart-abstracted measures, or the collection of data from federal registries like the NHSN), and to increase the utility of the data provided by the hospitals. In addition, 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.

For the claims-based measures, this section is not applicable, because these measures can be fully calculated based on data that are already reported to the Medicare program for payment purposes. Therefore, no additional information technology will be required of hospitals to collect data for these measures.

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect quality of care data from hospitals.

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. We define a "small hospital" as one with 1-99 inpatient beds. A pproximately 917 small subsection (d) hospitals were subject to validation as part of the HAC Reduction Program in the FY 2022 program year. We do not expect this number to change significantly for the FY 2025 program year.

No special processes or procedures are available to small hospitals to make the information collection less burdensome. We have previously finalized policies to make the processes under the HAC Reduction Program as similar as possible to the current Hospital IQR Program processes and anticipate that small hospitals participating in the Hospital IQR Program will continue to be familiar with the information collection request required for validation. We also provide a help-desk hotline for troubleshooting purposes and 24/7 free information available on the QualityNet website through a Questions and Answers (Q&A) function.

6. Less Frequent Collection

CMS has designed the collection of quality-of-care data to be the minimum necessary for data validation and for calculation of summary figures to be used as reliable estimates of hospital performance. Data validation is expected to occur quarterly, but as noted above, only up to 400 hospitals will be selected for validation. Neither less frequent collection of data nor validation of fewer cases is practicable at this time. Less frequent data collection would strain the ability for

CMS to validate the submitted validation template and associated NHSN HAI infection cases in a timely manner.

Under the current process, CMS Clinical Data Abstraction Center (CDAC) abstractors are able to review and validate hospital submissions as those submissions are made each quarter. If the hospitals submitted data less frequently, CDAC abstractors would not have time to complete the necessary reviews of each submission before the Total HAC Score is calculated. Similarly, if the HAC Reduction Program proposed to validate fewer cases, the statistical analysis would be altered, and the Program would be less likely to generate meaningful results from validation.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice for the FY 2025 IPPS/LTCH PPS proposed rule (RIN 0938-AV34, CMS-1808-P) was published on May 2, 2024 (89 FR 35934). No comments were received regarding the burden estimates included in this PRA package. The FY 2025 IPPS/LTCH PPS final rule (RIN 0938-AV34, CMS-1808-F) was published on August 28, 2024 (89 FR 68986).

CMS is additionally supported in this program's efforts by the CDC, Health Resources and Services Administration, and the Agency for Healthcare Research and Quality. 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 Respondents

No payments or gifts will be given to hospitals for participation. However, the HAC Reduction Program applies a 1-percent payment reduction or penalty to subsection (d) hospitals in the worst-performing quartile of all subsection (d) hospitals based on Total HAC score. The HAC Reduction Program may also penalize any hospitals that fail validation by assigning the maximum Winsorized *z*-score for the set of measures that fail validation, for use in the Total HAC Score calculation.

10. Confidentiality

We pledge privacy to the extent provided by law. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted. All information collected under the HAC Reduction 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. In addition, the tools used for transmission of data are considered confidential forms of communication, and there are safeguards in place in accordance with HIPAA Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. Only hospital-specific data will be made publicly available as mandated by

statute.

Data related to the HAC Reduction Program is housed in the Hospital Quality Reporting (HQR) application group. CMS' HQR is a General Support System (GSS) housing protected health information (PHI). Users who access CMS' 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 HAC Reduction Program is MBD 09-70-0536, as modified on February 14, 2018 (83 FR 6591).

11. Sensitive Questions

There are no questions of a sensitive nature associated with these information collections. Case-specific clinical data elements will be collected and are necessary to calculate statistical measures. These statistical measures are the basis of all subsequent improvement initiatives derived from this collection and cannot be calculated without 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 released to the public after hospitals have had an opportunity to review the data , as mandated by statute. The patient-specific data remaining in the CMS clinical data warehouse after the data are aggregated for release for public reporting will continue to be subject to the strict confidentiality regulations in 42 CFR Part 480.

12. Burden Estimates (Hours & Wages)

(a) Background

In the FY 2025 IPPS/LTCH PPS final rule, we are not adopting new measures or removing any existing measures for the HAC Reduction Program.

(b) Burden for the FY 2025 Program Year

For the purposes of burden estimation, we assume all activities associated with the HAC Reduction Program for 3,050 IPPS hospitals, of which up to 400 will be selected for validation of the data submitted for the NHSN measures associated with the FY 2025 program year.

For the purposes of burden estimation, we assume all activities associated with the HAC Reduction Program will be completed by Medical Records Specialists. These staff are qualified to complete the tasks associated with the chart-abstraction of patient data from medical records, the submission of data to clinical registries, and the completion of any of the other applicable forms associated with activities related to the HAC Reduction Program.

OMB has currently approved burden of 28,800 hours at a cost of approximately $1,221,120 under OMB control number 0938-1352, accounting for information collection burden experienced by up to 400 hospitals selected for validation annually. As shown in Table 2, using updated wage rates, we estimate a revised baseline burden of 28,800 hours at a cost of $1,501,056 for the FY 2025 program year. As previously discussed, this package excludes burden associated with the NHSN HAI data collection, which is captured under a separate OMB control number: 0920-0666. We also do not provide an estimate of burden for either the data collected or data validation associated with the claims-based PSI 90 measure, because this

measure is collected using Medicare FFS claims that hospitals are already submitting to the Medicare program for payment purposes and audited under the Medicare FFS Recovery Audit Program.

Table 2. Currently Approved Burden Estimates for the HAC Reduction Program for the FY 2025 Program Year

Measure Set	***Estimated time per record (hours) - FY 2025 Program Year***	***Number reporting quarters per year - FY 2025 Program Year***	***Number of respondents***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Burden Hours for FY 2025 Program Year***
HAI Validation Templates (CLABSI, CAUTI)	20	4	200	1	80	16,000
HAI Validation Templates (MRSA, CDI)	16	4	200	1	64	12,800
Total Burden Hours						**28,800**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$1,501,056**

(c) Updated Hourly Wage Rate

While the most recent data from the BLS reflects a median hourly wage of $22.69 per hour for all medical records specialists, $26.06 is the mean hourly wage for "general medical and surgical hospitals," which is an industry within medical records specialists (we note that BLS does not provide median occupation wage rates for individual industries).[1] We believe the industry of "general medical and surgical hospitals" is more specific to our settings for use in our calculations than other industries that fall under medical records specialists, such as "office of physicians" or "nursing care facilities." We calculate the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage, consistent with previous years. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly by employer and methods of estimating these costs vary widely in the literature. Nonetheless, we believe that doubling the hourly wage rate ($26.06 × 2 = $52.12) to estimate total cost is a reasonably accurate estimation method. Accordingly, we calculate cost burden to hospitals using a wage plus benefits estimate of $52.12 per hour for the HAC Reduction Program.

(d) Validation Template Submission Burden

The HAC Reduction Program is a payment program that assesses hospital performance with respect to healthcare safety of all subsection (d) hospitals using claims-based and NHSN HAI measures. While all claims-based data are submitted through claims processing systems that have

[1] Bureau of Labor Statistics, Occupational Employment and Wages. Accessed on March 7, 2024: https://www.bls.gov/oes/current/oes292072.htm.

validation methods to accept accurate Medicare claims into the claims database, the NHSN HAI data are not validated through other CMS processes. For the HAC Reduction Program to assess hospitals fairly, it must be able to ensure the accuracy of the data it collects. Validation is necessary to ensure the data used by the program are both correct and useful. To facilitate the HAC Reduction Program, validation templates for the CLABSI, CAUTI, MRSA, and CDI measures are used to ensure data accuracy are necessary.

The validation templates are dependent upon a hospital's selection for validation and may not be required by any particular hospital in any given year. To validate NHSN HAI data, CMS performs a random selection of up to 200 subsection (d) hospitals and an additional 200 hospitals using targeting criteria on an annual basis for validation of chart-abstracted measures. Each hospital selected for validation is required to produce a list of patients or lab results associated with the measure being validated quarterly. All hospitals selected for validation will have their SSI measure data validated, but hospitals do not need to submit a template for this measure for CMS to select cases for validation. Approximately 200 hospitals will be required to produce the CLABSI and CAUTI templates and the other approximately 200 hospitals will be required to produce only the MRSA and CDI templates.

We continue to estimate each hospital selected to produce the CLABSI and CAUTI validation templates will require 20 hours per quarter (80 hours annually) and each hospital selected to produce the MRSA and CDI validation templates will require 16 hours per quarter (64 hours annually). We estimate a total burden of 28,800 hours [(80 hours per hospital to submit CLABSI and CAUTI templates x 200 hospitals) + (64 hours per hospital to submit MRSA and CDI templates x 200 hospitals)] at a cost of $1,501,056 (28,800 hours x $52.12).

(e) Burden Associated with Completion of Forms

We continue to include the burden associated with the DACA form, Validation Education Review Form, and ECE Request form under OMB control number 0938-1022 for the Hospital IQR Program. We note that as finalized in the FY 2011 IPPS/LTCH PPS final rule regarding information collection burden associated with the Hospital IQR Program's request for reconsideration process, information collection requirements imposed subsequent to an administrative action are not subject to the Paperwork Reduction Act (PRA) under 5 CFR 1320.4(a)(2), therefore, the time required for hospitals to complete the Validation Reconsideration Request for Review Form is not included in our estimate of burden (75 FR 50411).

We previously included the burden associated with the Measure Exception Form for NHSN HAI Data Submission form under OMB control number 0938-1022. Beginning with the FY 2025 program year, we are accounting for the burden associated with this form under OMB control number 0938-1352 for the HAC Reduction Program. We estimate the form will require 10 minutes (0.167 hours) to submit and based on data from previous years, assume 240 hospitals will complete the form annually. As a result, we estimate a total burden of 40 hours annually (0.167 hours x 240 hospitals) at a cost of $2,085 (40 hours x $52.12). The total burden hours are 28,840.

Table 3. Summary of Annual Burden Estimates for the HAC Reduction Program for the

FY 2025 Program Year and Subsequent Years

Measure Set	*Estimated time per record (hours)*	*Number reporting quarters per year*	*Number of respondents*	*Average number records per hospital per quarter*	*Annual burden (hours) per hospital*	*Total Burden Hours*
HAI Validation Templates (CLABSI, CAUTI)	20	4	200	1	80	16,000
HAI Validation Templates (MRSA, CDI)	16	4	200	1	64	12,800
Measure Exception Form	0.167	1	240	1	0.167	40
Total Burden Hours						**28,840**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$1,503,141**

(f) Information Collection Instruments/Instructions

The validation templates for the CLABSI, CAUTI, MRSA, and CDI measures are updated annually to reflect the annual changes in fiscal year and beginning reporting quarter, as well as new CDC pathogen lists, with each new selection of hospitals for validation. The templates for each year are only utilized by the hospitals that are selected for validation. We are submitting updated versions of the templates as well as the Measure Exception Form for NHSN HAI Data Submission and Validation Reconsideration Request for Review Form under OMB control number 0938-1352.

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs associated with the HAC Reduction Program's policies.

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 $7,500,000 annually for the validation contract. Additionally, this program takes one and one-half (1.5) CMS staff at a GS-13 Step 5 level with approximate salaries of $133,692 plus benefits (30%) of $40,108 per staff member to operate for an additional cost of $260,700 (1.5 FTE x ($133,692 + $40,108)). The total annual cost to the Federal Government is $7,760,700.

For claims-based measures, the cost to the Federal Government is minimal. CMS uses data from the CMS National Claims History system that are already being collected for provider reimbursement; therefore, no additional data will need to be submitted by hospitals for claims-based measures.

15. Program or Burden Changes

We previously requested and received approval for total annual burden estimates under this OMB control number for the FY 2025 program year of 28,800 hours at a total cost of $1,221,120. Accounting for updated wage rates, the total cost increases to $1,501,056 as shown in Table 2, a difference of $279,936.

While we are updating wage rates, we are not finalizing any policies in the FY 2025 IPPS/LTCH PPS final rule which result in a change to our estimated burden. However, we are accounting for the burden of 40 hours at a cost of $2,085 associated with completion of the Measure Exception Form. In aggregate, we estimate a total increase of 40 hours and $282,021 ($279,936 + $2,085). The burden hours are now 28,840 (28,800 hours + 40 hours).

16. Publication/Tabulation Dates

The goal of the data collection is to validate NHSN HAI data. We will continue to display quality information for public viewing on the Compare website maintained by HHS or its successor website as required for the HAC Reduction Program by Section 1886(p)(6) of the Social Security Act. Data are presented on the Compare website in a format mainly aimed towards consumers, patients, and the general public; providing access to hospital-specific quality measure performance rates along with state and national performance rates. Hospital quality data on the Compare website are updated on a quarterly basis. One of the goals of the HAC Reduction Program is to publicly display data on all measures adopted for the Program. We note, however, that in certain circumstances we may decide to delay public display as we evaluate the accuracy of the measure data.

We will continue to display hospital quality information for public viewing as required by Social Security Act sections 1886(b)(3)(B)(viii)(VII) for the Hospital IQR Program, 1886(o)(10) for the Hospital VBP Program, 1886(p)(6) for the HAC Reduction Program, 1886(q)(6) for the Hospital Readmissions Reduction Program, and 1886(n)(4)(B) for the Medicare Promoting Interoperability Program. Hospital data from these initiatives are currently used to populate the Compare tool hosted by HHS, available at: https://www.medicare.gov/care-compare/, or its successor website(s). Data are presented on the Compare tool hosted by HHS in a format mainly aimed towards consumers, patients, and the general public, providing access to hospital-specific quality measure performance rates along with state and national performance rates. For certain outcome and cost measures, data are presented on the Compare tool hosted by HHS in performance categories of Better, No Different, or Worse than the National Rate. More detailed measure data, including the data used for the Compare tool hosted by HHS, are also available to the public as downloadable files at https://data.medicare.gov. Hospital quality data on the Compare tool hosted by HHS are currently updated on a quarterly basis.

17. Expiration Date

We will display the approved expiration date on each of the forms included as appendices to this PRA, which would become available on the QualityNet website (https://qualitynet.cms.gov) HAC Reduction Program page. We will also display the approved expiration date prominently on our QualityNet website's HAC Reduction Program pages used to document our measure specifications and reporting guidance.

18. Certification Statement

We are not claiming any exceptions to the Certification for Paperwork Reduction Act Submissions Statement.