Supporting Statement – Part A

Submission of Information for the Hospital Inpatient Quality Reporting (IQR) Program: FY 2025 IPPS/LTCH PPS Final Rule (OMB# 0938-1022, CMS-10210)

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, including for the inpatient hospital setting, 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 2029 payment determination are currently approved under OMB control number 0938-1022 (expiration date January 31, 2026). This request covers data collection requirements for the FY 2027 payment determination and subsequent years. This revised information collection request includes burden for the adoption of the Age Friendly Hospital measure, the increase in the number of eCQMs hospitals will be required to report, and the removal of the Measure Exception Form for NHSN HAI Measures from this information collection in addition to updated data and wage rates impacting previously approved burden calculations.

B. Justification

1. Need and Legal Basis

The Hospital IQR Program was first established to implement Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173), which authorized CMS to pay hospitals that successfully reported quality measures a higher annual update to their payment rates. Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171) revised the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. This is reflected in sections 1886(b)(3)(B)(viii)(I) and (II) of the Social Security Act, which provide that the Annual Payment Update (APU) will

be reduced for any subsection (d) hospital that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

Section 1886(o) of the Social Security Act mandates CMS' transition from a passive supplier of health care to an active purchaser of quality care. Pursuant to section 1886(o)(2)(A) of the Social Security Act, CMS must select measures for the Hospital VBP Program from the measures (other than measures of readmissions) specified under the Hospital IQR Program. Consistent with this legislation, CMS established a Hospital VBP Program, beginning effective with payment adjustments on FY 2013 discharges, which qualifies hospitals for financial incentives based on their performance on a defined set of quality measures selected for the Hospital VBP Program from the measures specified under the Hospital IQR Program.

(a) Hospital IQR Program Quality Measures

The FY 2027 APU determination will be based on Hospital IQR Program data reported and supporting forms submitted by hospitals on chart-abstracted measures, patient surveys, and eCQMs for calendar year (CY) 2025 discharges, as well as data validation for selected hospitals. In an effort to reduce burden, a variety of different data collection mechanisms are employed, with every consideration taken to employ data and data collection systems already in place.

The Hospital IQR Program seeks to collect and publicly report data on quality-of-care metrics for the hospital inpatient setting. Measure data are submitted via one of several modes: (1) chart-abstracted; (2) digital; (3) web-based; (4) claims-based; (5) hybrid measures; (6) survey-based; and (7) Patient-Reported Outcomes-Based Performance Measures (PRO-PM), 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 some 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 web-based measures, measure data are submitted differently depending on the measure. For measure data submitted via the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN), measures are calculated using data submitted to the NHSN under OMB control number 0920-1317 (expiration date March 31, 2026) for the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure and under OMB control number 0920-0666 (expiration date December 31, 2026) for the Influenza Vaccination Coverage Among HCP measure. 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).[1] For structural and process measures reported directly to

[1] Pub. L. 99-660.

CMS, hospitals are required to submit measure data via CMS' Hospital Quality Reporting (HQR) system.

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

Hybrid measures use both claims-based data and EHR data. The EHR data consists of a set of core clinical data elements consisting of vital signs and laboratory test information and patient linking variables collected from hospitals' EHR systems. We do not expect any additional burden to hospitals to report the claims-based portion of these measures because these data are already reported to the Medicare program for payment purposes. However, we do expect that hospitals will experience burden in reporting the EHR data.

For measure data submitted as "survey-based," information is derived through analysis of responses to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and requires hospitals to administer the survey and submit the survey data to CMS. These survey administration burdens are captured under OMB control number 0938-0981 (expiration date January 31, 2025).

The Hospital-Level Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Patient-Reported Outcomes-Based Performance Measure (PRO-PM) uses four sources of data for the calculation of the measure: (1) 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. Once hospitals collect the PRO data, it is submitted electronically via the CMS HQR system.

Table 1. Currently Approved Hospital IQR Program Measures for the FY 2026 Payment Determination

Measure Data Submission Mode and Name	Consensus-Based Entity No.
Chart-Abstracted Measures	
Severe Sepsis and Septic Shock Management Bundle Measure	0500
Hybrid Measures	
Hybrid Hospital-Wide All-Cause Readmission Measure	2879
Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure	3502
eCQMs	
Safe Use of Opioids - Concurrent Prescribing	3316
Cesarean Birth	N/A
Severe Obstetric Complications	N/A
Discharged on Antithrombotic Therapy	0435
Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436

Antithrombotic Therapy by the End of Hospital Day Two	0438
Venous Thromboembolism Prophylaxis	0371
Intensive Care Unit Venous Thromboembolism Prophylaxis	0372
Hospital Harm - Severe Hypoglycemia	3503
Hospital Harm - Severe Hyperglycemia	3533
Hospital Harm - Opioid Related Adverse Events	3501
Global Malnutrition Composite Score	3592
NHSN Measures	
Influenza Vaccination Coverage Among HCP*	0431
COVID-19 Vaccination Coverage Among HCP **	N/A
Claims-Based Measures	
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA/TKA	1550
Death Rate among Surgical Inpatients with Serious Treatable Complications	0351
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke	N/A
Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	2881
Excess Days in Acute Care after Hospitalization for Heart Failure	2880
Excess Days in Acute Care after Hospitalization for Pneumonia	2882
Medicare Spending Per Beneficiary (MSPB)	2158
Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	2431
Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)	2436
Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia	2579
Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	3474
Survey-Based Measures	
HCAHPS Survey***	0166
Patient-Reported Outcomes-Based Performance Measures	
Hospital-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure	3559
Structural Measures	
Hospital Commitment to Health Equity	N/A
Maternal Morbidity	N/A
Process Measures	
Screening for Social Drivers of Health	N/A
Screen Positive Rate for Social Drivers of Health	N/A

*Burden for this measure is accounted for under OMB control number 0920-0666.
**Burden for this measure is accounted for under OMB control number 0920-1317.
***Burden for this measure is accounted for under OMB control number 0938-0981.

(b) Summary of Finalized Hospital IQR Program Changes

In the FY 2025 IPPS/LTCH PPS final rule, we finalized two policies which will affect information collection burden under this OMB control number. We are adopting the Age Friendly Hospital measure beginning with the CY 2025 reporting period/FY 2027 payment determination as well as increasing the total number of eCQMs to be reported from six to eight for the CY 2026 reporting period/FY 2028 payment determination, from eight to nine eCQMs for the CY 2027 reporting period/FY 2029 payment determination, and then from nine to eleven eCQMs beginning with the CY 2028 reporting period/FY 2030 payment determination.

We also finalized several policies in the FY 2025 IPPS/LTCH PPS final rule which will not affect information collection burden under OMB control number 0938-1022. We are adopting three new measures for which data are collected via the NHSN under OMB control number 0920-0666: (1) the Patient Safety Structural measure beginning with the CY 2025 reporting period/FY 2027 payment determination; (2) the Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination; and (3) the Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 reporting period. We are adopting two new eCQMs which will be available for hospitals to self-select but will not increase the total number of eCQMs hospital must report, therefore resulting in no additional reporting burden: (1) the Hospital Harm - Falls with Injury eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination; and (2) the Hospital Harm - Postoperative Respiratory Failure eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination. We are adopting the Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) measure beginning with the July 1, 2023 – June 30, 2025 reporting period/FY 2027 payment determination which will be calculated using Medicare Advantage data and Medicare FFS claims that are already reported to the Medicare program for payment purposes. We are refining one measure currently in the Hospital IQR Program measure set, the Global Malnutrition Composite Score eCQM, beginning with the CY 2026 reporting period/FY 2028 payment determination, which is already available for hospitals to self-select, so will not increase the total number of eCQMs hospital must report nor change the reporting burden. We are also removing five measures calculated using Medicare FFS claims that are already reported to the Medicare program for payment purposes: (1) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) measure beginning with the July 1, 2021 – June 30, 2024 reporting period which is associated with FY 2026; (2) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF) measure beginning with the July 1, 2021 – June 30, 2024 reporting period which is associated with the FY 2026 payment determination; (3) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN) measure beginning with the July 1, 2021 – June 30, 2024 reporting period which is associated with the FY 2026 payment determination; (4) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure beginning with the April 1, 2021 – March 31, 2024 reporting period which is associated with the FY 2026 payment determination; and (5) Death Rate Among Surgical Inpatients with Serious Treatable Complications (CMS PSI-04) measure beginning with the July 1, 2023 – June 30, 2025

reporting period which is associated with the FY 2027 payment determination. Lastly, we are updating the scoring methodology for eCQM validation, removing the requirement that hospitals must submit 100 percent of eCQM records to pass validation beginning with CY 2025 eCQM data affecting the FY 2028 payment determination, and no longer requiring hospitals to resubmit medical records as part of their request for reconsideration of validation beginning with CY 2025 discharges affecting the FY 2028 payment determination. These updated data validation policies will not impact the estimated reporting burden.

We are also refining the HCAHPS Survey measure beginning with the CY 2025 reporting period/FY 2027 payment determination. As noted previously, information collection burden associated with the HCAHPS Survey measure is currently approved under OMB control number 0938-0981, and the updates will be submitted to OMB for approval.

(c) Hospital IQR Program Administrative Forms

CMS has implemented procedural requirements that align the current quality reporting programs, including the Hospital IQR Program, the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, Hospital Readmissions Reduction, Hospital Outpatient Quality Reporting, Hospital-Acquired Condition (HAC) Reporting, and Hospital Value-Based Purchasing (VBP) Programs. These procedural requirements involve submission of forms to comply with hospital quality program requirements. As a result, many of the forms are used for multiple programs but are included under OMB control number 0938-1022 to reduce administrative burden and the potential for errors when updates are necessary.

The Hospital IQR Program and other current quality reporting programs use ten administrative forms: (1) Notice of Participation Form; (2) Data Accuracy and Completeness Acknowledgement (DACA) Form; (3) Request Form for Withholding/Footnoting Data from Public Reporting; (4) Quality Reporting Program APU Reconsideration Request Form; (5) Quality Reporting Validation Educational Review Form; (6) Validation Review for Reconsideration Request Form; (7) Extraordinary Circumstances Exception (ECE) Request; (8) Hospital VBP Program Review and Corrections Request Form; (9) Hospital VBP Appeal Request Form; and (10) Hospital VBP Independent CMS Review Request Form. We note that the Measure Exception Form for Perinatal Care (PC) and HAI Data Submission previously included under this OMB control number will now be included under OMB control number 0938-1352 for the HAC Reduction Program. We discuss measure data collection forms in section B.12.o. These forms 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 the Rural Emergency Hospital Quality Program). None of these administrative 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, with the exception of the DACA Form, which is completed annually. The burden for providers associated with forms is discussed in section B.12.k.

a. Notice of Participation Form

To begin participation in the Hospital IQR Program, subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Social Security Act) paid under the Inpatient Prospective Payment System (IPPS) must complete a Hospital IQR Notice of Participation. The Notice of Participation explains the participation and reporting requirements for the program. The form explains that in order to receive the full market basket update or APU, the hospitals are agreeing to submit data on selected measures and allowing CMS to publish their data for public viewing according to section 1886(b)(3)(B)(viii) of the Social Security Act. We note that the Notice of Participation as well as other forms discussed here and listed in section B.12.o have been previously approved under OMB control number 0938-1022. Other hospitals not paid under the IPPS, such as critical access hospitals (CAHs), may also wish to voluntarily submit data and have their data published for public viewing. In order to accommodate these hospitals, a separate section of the participation form, referred to as the Optional Public Reporting Notice of Participation, is available for these hospitals to give CMS permission to collect and publish data that are voluntarily submitted by a hospital. These hospitals may choose to suppress a measure or measures prior to their posting on the Compare tool hosted by HHS, currently available at: https://www.medicare.gov/care-compare, or its successor website(s).

Hospitals that indicated their intent to participate will be considered active Hospital IQR Program participants until they submit a withdrawal to CMS. Hospitals that no longer wish to participate in the Hospital IQR Program or those that no longer wish to submit data for publishing on the Compare tool can notify CMS of their decision using the same form discussed above.

b. DACA Form

Annually, hospitals participating in quality reporting submit 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 acknowledgment that the data a hospital has submitted are complete and accurate.

c. Request Form for Withholding/Footnoting Data from Public Reporting

Hospitals that voluntarily participate in quality reporting but are not paid under the IPPS may elect to have those data withheld from public reporting by completing the Request Form for Withholding/Footnoting Data from Public Reporting. Once the form is submitted, data can be withheld for the quarter in which the form is submitted. However, the data will be released on the Compare tool for subsequent releases unless the hospital submits a new Request Form for Withholding/Footnoting Data from Public Reporting indicating the measure(s) the hospital would like to withhold from public reporting for the period.

d. APU Reconsideration Request Form

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

When CMS determines that a hospital did not meet one or more of the Hospital IQR Program requirement(s), the hospital may submit a request for reconsideration to CMS using the CMS Quality Reporting Program APU Reconsideration Request Form, by the deadline identified on the Hospital IQR Program APU Notification Letter it received. For reconsideration requests related specifically to the validation requirements, hospitals must use the CMS Hospital IQR Program Validation Review for Reconsideration Request Form.

e. Validation Educational Review Form

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

f. Validation Review for Reconsideration Request Form

If CMS determines that a hospital did not meet any of the Hospital IQR Program requirements due to a confidence interval validation score of less than 75 percent and the hospital would like to request a reconsideration, the hospital must complete and submit this form, along with a copy of the entire medical record for the appealed element(s). In the FY 2025 IPPS/LTCH PPS final rule, we are finalizing no longer requiring hospitals to resubmit medical records as part of their request for reconsideration of validation beginning with CY 2025 discharges affecting the FY 2028 payment determination.

g. ECE Request Form

CMS offers a process for hospitals to request exceptions to the reporting of required quality data, including eCQM data, for one or more quarters when a hospital experiences an extraordinary circumstance beyond the hospital's control. The CMS Quality Program ECE Request Form indicates that for non-eCQM circumstances, the request must be submitted within 90 calendar days of an extraordinary circumstance event for all programs. In addition, the form indicates that for eCQM reporting circumstances under the Hospital IQR Program and Hospital OQR Program, the request must be submitted by April 1st following the end of a reporting period calendar year.

h. Hospital VBP Program Review and Corrections Request Form

We may only select measures for the Hospital VBP Program from the measures (other than measures of readmissions) specified under the Hospital IQR Program. Hospitals may appeal the calculation of their performance assessment with respect to the performance standards, as well as

their Total Performance Score (TPS), for the Hospital VBP Program. Hospitals may review and request recalculation of their hospital's performance scores on each condition, domain, and TPS using the Hospital VBP Program Review and Corrections Request Form within 30 calendar days of the posting date of the Value-Based Percentage Payment Summary Report.

i. Hospital VBP Appeal Request Form

CMS has implemented an additional appeal process available to eligible hospitals participating in the Hospital VBP Program, beyond the existing Review and Corrections process. Hospitals must submit an Appeal Request within 30 calendar days from the date CMS informed the hospital through Hospital Quality Reporting of its decision on the Review and Corrections Request.

j. Hospital VBP Independent CMS Review Request Form

CMS has implemented an independent review that is an additional appeal process available to eligible hospitals participating in the Hospital VBP Program, beyond the existing Review and Corrections process and Appeal process. Hospitals dissatisfied with the outcome of an Appeal may request an Independent CMS Review. Hospitals are strongly encouraged to request the Independent CMS Review within 30 days after they receive a decision on their Appeal. Hospitals can anticipate a review decision within 90 calendar days following receipt of the Independent CMS Review Request.

2. Information Users

The Hospital IQR 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. CMS provides confidential feedback reports that hospitals may use to assess their performance and operationalize quality improvement activities throughout the quality reporting period. These reports include the data that CMS has collected from the hospital and the hospital's claims, and some also include information about how the hospital's data compare relative to the performance of other hospitals. For example, the Facility, State and National (FSN) Report allows hospitals to compare their performance related to a specific measure during a specific timeframe, to the average performance of other hospitals at the state and national levels.

CMS will use the information collected from hospital quality reporting to set payment adjustments for value-based purchasing. For example, the Hospital VBP Program Baseline Measures Report allows hospitals to compare their performance for each measure to the program's benchmarks and achievement thresholds, which are obtained from the scores of all hospitals. These reports allow hospitals time to assess how their current performance in each measure could be scored in the upcoming Hospital VBP payment determinations while there is still time to target improvement activities related to specific measures so that their performance and scores can be maximized.

Hospital measure information is also used by CMS to direct its contractors to focus on particular areas of improvement and to develop quality improvement initiatives. Medicare beneficiaries experience a high rate of preventable readmissions, which are burdensome to patients and families, as well as costly. Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs), under contract with CMS, use readmissions data from CMS to assist communities to reduce avoidable readmissions. For example, the QIN-QIO program helps communities with high readmission rates form local coalitions, identify the factors driving avoidable hospital readmissions in their area, and find ways to better coordinate care and to encourage patients to manage their health more actively.

This information is also available to Medicare beneficiaries, as well as to the general public, by providing hospital information on the Compare tool and in the Provider Data Catalog (PDC) available at data.cms.gov 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). Under emergency circumstances, consumers choose hospitals based on proximity, reputation, prior experience, or their doctor's recommendation. For childbirth or elective hospital admissions, when patients and their family members may have the time and motivation to consider options and engage in informed decision making, they have expressed interest in information such as the provider's track record in treating their condition, safety and infection rates, and a hospital's recognized areas of expertise, as well as to take into consideration their doctor's recommendation.

Under section 1890A(a)(6) of the Social Security Act, 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 IQR Program and other CMS programs, CMS' findings were formally written into the latest triennial National Impact Assessment Report, which was released in CY 2024.[2]

3. Use of Information Technology

[2] The latest 2024 Impact Assessment Report, as well as earlier reports from 2012, 2015, 2018, and 2021 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.

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 (for example, the automated collection of electronic patient data in EHRs for eCQMs and hybrid measures, 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. CMS also provides a secure data warehouse via the 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.

As reflected by the collection and reporting of claims-based quality measures, quality measures submitted via the HQR system, and measures which are digitally-derived (for example, 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 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.

For the claims-based measures or measures which collect data from claims, Medicare Advantage encounter data, and other administrative data in part, this section is not applicable, because these measures can be fully or partially 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 these 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 for hospital inpatient care. CMS requires hospitals to submit quality measure data for services provided in the inpatient setting. We prioritize efforts to reduce reporting burden for the collection of quality of care information by utilizing electronic data that hospitals already report to The Joint Commission for accreditation, as well as aligning eCQMs and related reporting requirements with the Medicare Promoting Interoperability Program for Eligible Hospitals and CAHs.

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. The Hospital IQR Program included approximately 917 participating IPPS small hospitals for the FY 2025 payment determination and 14 small hospitals located in Maryland or Puerto Rico. In addition, as defined under 42 CFR Part 485 subpart F, a CAH (referred to as a non-IPPS hospital under the Hospital IQR Program) may have no more than 25 inpatient beds. We estimate approximately 1,400 CAHs could voluntarily participate in the Hospital IQR Program; therefore, we assume all 1,400 CAHs hospitals would qualify as small hospitals. As a result, we estimate a total of 2,331 small hospitals (917 IPPS + 14 Maryland/Puerto Rico + 1,400 CAHs) will submit data for the Hospital IQR Program for the CY 2025 reporting period.

The Health Resources & Services Administration's Medicare Rural Hospital Flexibility Program (Flex) and Medicare Beneficiary Quality Improvement Project, as well as CMS' Quality Improvement Organizations, provide technical assistance to small hospitals to reduce burden and improve healthcare quality. 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 function.

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. Frequency of data collection may vary (monthly, quarterly, annually, etc.) based on how a quality measure is specified. The following table details the frequency of data submission to CMS by measure type.

Table 2. Frequency of Data Submission by Measure Type

Measure Type	Frequency of Data Submission
Chart-abstracted	Quarterly
Structural and process measures	Annually
Survey measures	Quarterly
NHSN (other than COVID-19 Vaccination Coverage Among HCP measure) and EHR-based (for example, eCQMs, hybrid measures)	Annually
NHSN COVID-19 Vaccination Coverage Among HCP measure	Quarterly
Patient Reported Outcome-Performance Measures	Semi-annually

Claims-based measures are calculated from Medicare FFS claims data and Medicare Advantage encounter data; hospitals submit claims for reimbursement or payment per claims processing timeliness requirements. 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

There are no special circumstances.

8. *Federal Register* Notice/Outside Consultation

A 60-day *Federal Register* notice of the FY 2025 IPPS/LTCH PPS proposed rule (RIN 0938-AV34, CMS-1808-P) was published on May 2, 2024 (89 FR 35934). Comments received regarding the burden estimates are 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).

Measures adopted for the Hospital IQR Program are required by statute to undergo a recognized consensus process. Section 1890(b) of the Social Security Act requires CMS to consider input on the selection of quality and efficiency measures from a multistakeholder group convened by

the "consensus-based entity." To fulfill this requirement, the Partnership for Quality Measurement (PQM) provides 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.

CMS is additionally supported in this program's efforts by The Joint Commission, 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 (for example solicitation of comments).

9. Payment/Gift 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

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 Hospital IQR 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 Hospital IQR Program is housed in the 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 Hospital IQR 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 forms. 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 that are to be made public with respect to the hospital, 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 Estimate (Total Hours & Wages)

(a) Background

In the FY 2025 IPPS/LTCH PPS final rule, we finalized two policies which affect information collection burden. We are adopting the Age Friendly Hospital measure beginning with the CY 2025 reporting period/FY 2027 payment determination as well as increasing the total number of eCQMs reported from six to eight for the CY 2026 reporting period/FY 2028 payment determination, from eight to nine eCQMs for the CY 2027 reporting period/FY 2029 payment determination, and then from nine to eleven eCQMs beginning with the CY 2028 reporting period/FY 2030 payment determination.

We discuss other policies finalized in the FY 2025 IPPS/LTCH PPS final rule which will not affect information collection burden under OMB control number 0938-1022 in section B.1.a.

(b) Burden for the FY 2027 Payment Determination

Our currently approved burden estimates are based on an assumption of approximately 3,150 IPPS hospitals and 1,350 non-IPPS hospitals. Based on data from the FY 2024 Hospital IQR Program payment determination, we are updating our assumption and estimate that approximately 3,050 IPPS hospitals and 1,500 non-IPPS hospitals (comprised of 1,400 CAHs and approximately 100 hospitals located in Maryland and Puerto Rico) will report data to the Hospital IQR Program for the CY 2025 reporting period and subsequent years. For the purposes of burden estimation, we assume all activities associated with the Hospital IQR Program will be completed by Medical Records Specialists, with the exception of survey completion which will be completed by patients. These staff are qualified to complete the tasks associated with the chart-abstraction of patient data from medical records, the submission of electronic data from EHRs, the submission of data to clinical registries, and the completion of any of the other applicable forms associated with activities related to the Hospital IQR Program.

OMB has currently approved 2,286,977 hours at a cost of approximately $80.3 million under OMB control number 0938-1022, accounting for information collection burden experienced by approximately 3,150 IPPS hospitals and 1,350 non-IPPS hospitals for the FY 2026 payment determination. As shown in Table 3, using our updated assumption of 3,050 IPPS and 1,500 non-IPPS hospitals and updated wage rates, we estimate a revised baseline burden of 2,264,197 hours at a cost of $91.6 million for the FY 2026 payment determination. As previously stated, our burden estimates exclude burden associated with the NHSN under OMB control number 0920-0666 (expiration date December 31, 2026), the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure under OMB control number 0920-1317 (expiration date March 31, 2026), the HCAHPS Survey measure under OMB control number 0938-0981 (expiration date January 31, 2025), and the Health Insurance Common Claims Form and

Supporting Regulations under OMB control number 0938-1197 (expiration date December 31, 2024).

Table 3. Currently Approved Burden Estimates for the Hospital IQR Program Measure Set and Other Activities for the FY 2026 Payment Determination

Measure Set	*Estimated time per record (minutes) - FY 2026 payment determination*	*Number reporting quarters per year - FY 2026 payment determination*	*Number of respondents*	*Average number records per hospital per quarter*	*Annual burden (hours) per hospital*	*Total Burden Hours for FY 2026 payment determination*
CHART ABSTRACTION						
IPPS Hospitals (3,050)						
Sepsis measure	60	4	3,050	100	400	1,220,000
Non-IPPS Hospitals (1,500)						
Sepsis measure	60	4	362	25	100	36,200
Chart Abstracted Measure Subtotal (IPPS and Non-IPPS)						**1,256,200**
HYBRID MEASURES						
IPPS Hospitals (3,050)						
Hybrid HWR measure	10	4	3,050	1	0.67	2,033
Hybrid HWM Measure	10	4	3,050	1	0.67	2,033
Non-IPPS Hospitals (1,500)						
Hybrid HWR measure	10	4	1,500	1	0.67	1,000
Hybrid HWM measure	10	4	1,500	1	0.67	1,000
Hybrid Measure Subtotal (IPPS and Non-IPPS)						**6,067**
STRUCTURAL MEASURES						
IPPS Hospitals (3,050)						
Maternal Morbidity measure	5	1	3,050	1	0.083	254
Hospital Commitment to Health Equity measure	10	1	3,050	1	0.167	509
Non-IPPS Hospitals (1,500)						
Maternal Morbidity measure	5	1	1,500	1	0.083	125
Hospital Commitment to Health Equity measure	10	1	1,500	1	0.167	250

Structural Measure Subtotal (IPPS and Non-IPPS)						**1,138**
REPORTING eCQMs						
IPPS Hospitals (3,050)						
Reporting 6 eCQMs	60	4	3,050	1	4.00	12,200
Non-IPPS Hospitals (1,500)						
Reporting 6 eCQMs	60	4	1,500	1	4.00	6,000
eCQM Subtotal (IPPS and Non-IPPS)						**18,200**
PROCESS MEASURES						
IPPS Hospitals (3,050)						
Screening for Social Drivers of Health measure (Survey)	0.033	1	18,765,000	1	205.1	625,500
Screening for Social Drivers of Health measure (Reporting)	10	1	3,050	1	0.167	509
Screen Positive Rate for Social Drivers of Health measure	10	1	3,050	1	0.167	509
Non-IPPS Hospitals (1,500)						
Screening for Social Drivers of Health measure (Survey)	0.033	1	9,230,000	1	205.1	307,667
Screening for Social Drivers of Health measure (Reporting)	10	1	1,500	1	0.167	250
Screen Positive Rate for Social Drivers of Health measure	10	1	1,500	1	0.167	250
Process Measures Subtotal (IPPS and Non-IPPS)						**934,685**
PRO-PM MEASURES						
IPPS Hospitals (3,050)						
THA/TKA PRO-PM measure (Survey)	7.25	N/A	61,875	N/A	2.45	7,477
THA/TKA PRO-PM measure (Reporting)	10	2	1,525	1	0.33	509
Non-IPPS Hospitals (1,500)						
THA/TKA PRO-PM measure (Survey)	7.25	N/A	*	N/A	1.11	*
THA/TKA PRO-PM measure (Reporting)	10	2	750	1	0.33	250
PRO-PM Measures Subtotal						**8,236**
OTHER ACTIVITIES **All Hospitals (3,050 IPPS + 1,500 Non-IPPS)**						
Population and sampling for the ongoing measure sets	15	4	4,550	4	4	18,200
Review reports for claims-based measure sets	60	4	4,550	1	4	18,200

eCQM Validation	10	4	400	8	5.33	2,133
All other forms used in the data collection process	15	1	4,550	1	0.25	1,138
Subtotal other activities						**39,671**
Total Burden Hours						**2,264,197**
Total Burden for Surveys @ Average Individual Labor rate (940,644 hours x $24.04/hr)						**$22,613,082**
Total Burden @ Medical Records Specialist labor rate (1,323,553 hours x $52.12/hr)						**$68,983,582**
Total Burden						**$91,596,647**

* We are not able to accurately distinguish the number of Hospital-Level THA/TKA procedures that take place in IPPS hospitals from those conducted in non-IPPS hospitals. As a result, we combine the IPPS and non-IPPS hospital burden associated with completion of the pre-operative and post-operative surveys.

Changes to currently approved burden estimates due to policies in the FY 2025 IPPS/LTCH PPS final rule are discussed below.

(c) Updated Hourly Wage Rate

We previously utilized the median hourly wage rate for Medical Records Specialists, in accordance with the Bureau of Labor Statistics (BLS), to calculate our burden estimates for the Hospital IQR Program. 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).[3] 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 Hospital IQR Program.

(d) Chart-Abstracted Measure Reporting and Submission Burden

We are not making any changes to the reporting or submission requirements for the Severe Sepsis and Septic Shock measure in the FY 2025 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2026 payment determination, we currently estimate the information collection burden associated with the reporting of chart-abstracted measures to be 60 minutes or 1 hour per record for the Severe Sepsis and Septic Shock measure. We continue to assume that each IPPS hospital will report 100 records quarterly for a total annual burden of 400 hours (1 hour/record x 100 records x 4 quarters) per IPPS hospital. We estimate an annual burden of 1,220,000 hours

[3] U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed January 3, 2024. Available at: https://www.bls.gov/oes/current/oes292072.htm.

(400 hours/hospital x 3,050 IPPS hospitals) at a cost of $63,586,400 (1,220,000 hours x $52.12/hour) across all IPPS hospitals. We also estimate an annual burden of 36,200 hours (100 hours/hospital x 362 non-IPPS hospitals) at a cost of $1,886,744 (36,200 hours x $52.12/hour) across all participating non-IPPS hospitals.

(e) eCQM Reporting and Submission Burden

In the FY 2025 IPPS/LTCH PPS final rule, we are adopting two new eCQMs beginning with the CY 2026 reporting period/FY 2028 payment determination from which hospitals may self-select in order to meet their eCQM reporting requirements: (1) the Hospital Harm - Falls With Injury eCQM, and the (2) Hospital Harm - Postoperative Respiratory Failure eCQM. We are also modifying the Global Malnutrition Composite Score eCQM to add patients ages 18 to 64 to the current cohort of patients 65 years or older beginning with the CY 2026 reporting period/FY 2028 payment determination. Neither the addition of these two eCQMs to the eCQM measure set nor the modification of the Global Malnutrition Composite Score eCQM affects the information collection burden associated with submitting eCQM measure data under the Hospital IQR Program. While this policy results in new eCQMs being added to the Hospital IQR Program measure set, hospitals are not required to report more than a total of six eCQMs for the CY 2025 reporting period/FY 2027 payment determination and subsequent years.

In the FY 2025 IPPS/LTCH PPS final rule, we are modifying the eCQM reporting and submission requirements whereby we are increasing the total number of eCQMs to be reported from six to eight eCQMs for the CY 2026 reporting period/FY 2028 payment determination, from eight to nine eCQMs for the CY 2027 reporting period/FY 2029 payment determination, and then from nine to eleven eCQMs beginning with the CY 2028 reporting period/FY 2030 payment determination. We previously finalized in the FY 2023 IPPS/LTCH PPS final rule that, for the CY 2024 reporting period/FY 2026 payment determination and subsequent years, hospitals are required to submit four quarters of data for six eCQMs each year which must consist of the Safe Use of Opioids-Concurrent Prescribing, Cesarean Birth, and Severe Obstetric Complications eCQMs in addition to three self-selected eCQMs (87 FR 49387). We are finalizing that, for the CY 2026 reporting period/FY 2028 payment determination, hospitals will be required to submit data for eight total eCQMs: three self-selected and the Safe Use of Opioids, Severe Obstetric Complications, Cesarean Birth, Hospital Harm - Severe Hypoglycemia, and Hospital Harm - Severe Hyperglycemia eCQMs. We are also finalizing that, for the CY 2027 reporting period/FY 2029 payment determination, hospitals will be required to submit data for these eight eCQMs in addition to the Hospital Harm - Opioid-Related Adverse Events eCQM. Lastly, we are finalizing that, beginning with the CY 2028 reporting period/FY 2030 payment determination, hospitals will be required to submit data for these nine eCQMs as well as the Hospital Harm - Pressure Injury and Hospital Harm - Acute Kidney Injury eCQMs.

We continue to estimate the information collection burden associated with the eCQM reporting and submission requirements to be 10 minutes per measure per quarter of eCQM data. For the CY 2025 reporting period/FY 2027 payment determination, we estimate the information collection burden associated with the eCQM reporting and submission requirements to be 60 minutes (1 hour) per hospital per quarter of eCQM data (10 minutes x 6 eCQMs) with a total burden estimate of 3,050 hours across all IPPS hospitals (1 hour × 3,050 IPPS hospitals) for each

quarter of eCQM data. We therefore estimate a total burden of 12,200 hours (3,050 IPPS hospitals x one hour x 4 quarters) at a cost of $635,864 (12,200 hours x $52.12/hour) for reporting four quarters of eCQM data for all IPPS hospitals. We also estimate a total burden of 6,000 hours (1,500 non-IPPS hospitals x one hour x 4 quarters) at a cost of $312,720 (6,000 hours x $52.12/hour) for reporting four quarters of eCQM data for all non-IPPS hospitals.

For the CY 2026 reporting period/FY 2028 payment determination, we estimate a total of 80 minutes or 1.33 hours (10 minutes × 8 eCQMs) per hospital per quarter of eCQM data. We estimate a total burden of across all participating IPPS hospitals of 16,267 hours (1.33 hours x 3,050 IPPS hospitals × 4 quarters) at a cost of $847,836 (16,267 hours × $52.12). We also estimate a total burden of 8,000 hours (1.33 hours x 1,500 non-IPPS hospitals x 4 quarters) at a cost of $416,960 (8,000 hours x $52.12/hour) for reporting four quarters of eCQM data for all non-IPPS hospitals.

For the CY 2027 reporting period/FY 2029 payment determination, we estimate a total of 90 minutes or 1.5 hours (10 minutes × 9 eCQMs) per hospital per quarter of eCQM data. We estimate a total burden of across all participating IPPS hospitals of 18,300 hours (1.5 hours x 3,050 IPPS hospitals × 4 quarters) at a cost of $953,796 (18,300 hours × $52.12). We also estimate a total burden of 9,000 hours (1.5 hours x 1,500 non-IPPS hospitals x 4 quarters) at a cost of $469,080 (9,000 hours x $52.12/hour) for reporting four quarters of eCQM data for all non-IPPS hospitals.

For the CY 2028 reporting period/FY 2030 payment determination, we estimate a total of 110 minutes or 1.83 hours (10 minutes × 11 eCQMs) per hospital per quarter of eCQM data. We estimate a total burden across all participating IPPS hospitals of 22,326 hours annually (1.83 hours × 3,050 IPPS hospitals x 4 quarters) at a cost of $1,163,631 (22,326 hours × $52.12). We also estimate a total burden of 11,000 hours annually (1.83 hours x 1,500 non-IPPS hospitals × 4 quarters) at a cost of $573,320 (11,000 hours × $52.12) for reporting four quarters of eCQM data for all non-IPPS hospitals.

For the Excessive Radiation Dose eCQM, hospitals would log in through the measure developer's secure portal and run the free Alara Imaging Software for CMS Measure Compliance (or similar software) inside their firewall. The software runs automatically to create the three intermediate data elements needed for the measure. Once the software finishes creating these intermediate variables, hospitals can send the data to its EHR for measure calculation and reporting. The software allows additional options such as the ability to send the data to other business associates of the hospital if needed. No manual data entry is required. While this eCQM is not mandatory but is instead an eCQM available for hospitals to self-select, for estimating purposes we assume all hospitals will report this eCQM. In future years when we have data on the number of hospitals electing to report this eCQM, we may update our estimate at that time. We estimate that each hospital will spend approximately 15 minutes (0.25 hours) annually to conduct these activities prior to data submission and therefore estimate a total annual burden of 763 hours (0.25 hours x 3,050 hospitals) at a cost of $39,742 (763 hours x $52.12/hour) for all IPPS hospitals. We also estimated a total annual burden of 375 hours (0.25 hours x 1,500 hospitals) at a cost of $19,545 (375 hours x $52.12/hour) for all non-IPPS hospitals.

Table 4. Estimated Burden for the eCQM Reporting and Submission Requirements for the FY 2027 through FY 2030 Payment Determination Years

eCQM Measure Reporting	*Estimated time per record (minutes)*	*Number reporting quarters per year*	*Number of hospitals reporting*	*Average number records per hospital per quarter*	*Annual burden (hours) per hospital*	*Total Annual Hours for all hospitals*
FY 2027 Payment Determination						
Reporting 6 eCQMs (IPPS Hospitals)	60	4	3,050	1	4	12,200
Reporting 6 eCQMs (Non-IPPS Hospitals)	60	4	1,500	1	4	6,000
Login and Run Software for Excessive Radiation Dose eCQM (IPPS Hospitals)	15	1	3,050	1	0.25	763
Login and Run Software for Excessive Radiation Dose eCQM (Non-IPPS Hospitals)	15	1	1,500	1	0.25	375
Total Burden Hours						**19,338**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$1,007,871**
FY 2028 Payment Determination						
Reporting 8 eCQMs (IPPS Hospitals)	80	4	3,050	1	5.33	16,267
Reporting 8 eCQMs (Non-IPPS Hospitals)	80	4	1,500	1	5.33	8,000
Login and Run Software for Excessive Radiation Dose eCQM (IPPS Hospitals)	15	1	3,050	1	0.25	763
Login and Run Software for Excessive Radiation Dose eCQM (Non-IPPS Hospitals)	15	1	1,500	1	0.25	375
Total Burden Hours						**25,404**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$1,324,083**
FY 2029 Payment Determination						
Reporting 9 eCQMs (IPPS Hospitals)	90	4	3,050	1	6	18,300
Reporting 9 eCQMs	90	4	1,500	1	6	9,000

(Non-IPPS Hospitals)						
Login and Run Software for Excessive Radiation Dose eCQM (IPPS Hospitals)	15	1	3,050	1	0.25	763
Login and Run Software for Excessive Radiation Dose eCQM (Non-IPPS Hospitals)	15	1	1,500	1	0.25	375
Total Burden Hours						**28,438**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$1,482,163**
FY 2030 Payment Determination and Subsequent Years						
Reporting 11 eCQMs (IPPS Hospitals)	110	4	3,050	1	7.33	22,326
Reporting 11 eCQMs (Non-IPPS Hospitals)	110	4	1,500	1	7.33	11,000
Login and Run Software for Excessive Radiation Dose eCQM (IPPS Hospitals)	15	1	3,050	1	0.25	763
Login and Run Software for Excessive Radiation Dose eCQM (Non-IPPS Hospitals)	15	1	1,500	1	0.25	375
Total Burden Hours						**34,464**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$1,796,238**

(f) Structural Measure Reporting and Submission Burden

We are not making any changes to the reporting or submission requirements for the Maternal Morbidity Structural and Hospital Commitment to Health Equity measures in the FY 2025 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2026 payment determination, we currently estimate the information collection burden associated with the reporting of the Maternal Morbidity and Hospital Commitment to Health Equity measures to be 5 minutes (0.083 hours) and 10 minutes (0.167 hours) per hospital per year, respectively.

Reporting on the Maternal Morbidity Structural measure involves each hospital responding to a single question using a web-based tool available via CMS' HQR System with one of the following response options: (A) "Yes"; (B) "No"; or (C) "N/A (our hospital does not provide inpatient labor/delivery care)." Hospitals are required to submit responses for this structural measure on an annual basis during the submission period. We estimate an annual burden of 254 hours across all IPPS hospitals (0.083 hours × 3,050 IPPS hospitals) at a cost of $13,247 (254 hours × $52.12/hour) and an annual burden estimate of 125 hours across all non-IPPS hospitals (0.083 hours x 1,500 non-IPPS hospitals) at a cost of $6,515 (125 hours x $52.12/hour).

Reporting on the Hospital Commitment to Health Equity measure involves each hospital being required to provide responses and attest "yes" or "no" in response to as many as five questions one time per year for a given reporting period through CMS' HQR System. We estimate an annual burden of 509 hours across all IPPS hospitals (0.167 hours × 3,050 IPPS hospitals) at a cost of $26,529 (509 hours × $52.12/hour) and an annual burden of 250 hours across all non-IPPS hospitals (0.167 hours × 1,500 non-IPPS hospitals) at a cost of $13,030 (250 hours × $52.12/hour).

In the FY 2025 IPPS/LTCH PPS final rule, we are adopting the Age Friendly Hospital measure beginning with the CY 2025 reporting period/FY 2027 payment determination. Hospitals will be required to provide responses and attest "yes" or "no" in response to a total of five domains annually during the submission period for a given reporting period through CMS' HQR System. Similar to the Hospital Commitment to Health Equity measure, we estimate the burden associated with reporting this measure to CMS to be, on average across all 3,050 IPPS hospitals, no more than 10 minutes per hospital per year. Using the estimate of 10 minutes (or 0.167 hours) per hospital per year, we estimate a total annual burden of 509 hours across all IPPS hospitals (0.167 hours × 3,050 IPPS hospitals) at a cost of $26,529 (509 hours × $52.12) and an annual burden of 250 hours across all non-IPPS hospitals (0.167 hours × 1,500 non-IPPS hospitals) at a cost of $13,030 (250 hours × $52.12).

As previously stated, the burden associated with adoption of the Patient Safety Structural measure discussed in the FY 2025 IPPS/LTCH PPS final rule is not included under OMB control number 0938-1022 because the data for this measure will be collected via the NHSN under OMB control number 0920-0666.

Table 5. Estimated Burden for Structural Measure Reporting for the FY 2027 through FY 2029 Payment Determination Years

Structural Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 2027 through FY 2029 Payment Determination Years						
Maternal Morbidity measure (IPPS Hospitals)	5	1	3,050	1	0.083	254
Maternal Morbidity measure (Non-IPPS Hospitals)	5	1	1,500	1	0.083	125
Subtotal Burden Hours						**379**
Hospital Commitment to Health Equity measure (IPPS	10	1	3,050	1	0.167	509

Hospitals)						
Hospital Commitment to Health Equity measure (Non-IPPS Hospitals)	10	1	1,500	1	0.167	250
Subtotal Burden Hours						**759**
Age Friendly Hospital measure (IPPS Hospitals)	10	1	3,050	1	0.167	509
Age Friendly Hospital measure (Non-IPPS Hospitals)	10	1	1,500	1	0.167	250
Subtotal Burden Hours						**759**
Total Burden Hours						**1,897**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$98,880**

(g) Hybrid Measure Reporting and Submission Burden

We are not making any changes to the reporting or submission requirements for the Hybrid HWR and Hybrid HWM measures in the FY 2025 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2026 payment determination, we currently estimate the information collection burden associated with the reporting of hybrid measures to be 10 minutes (0.167 hours) per measure per quarter for each hospital or 80 minutes (1.33 hours) for both measures annually (10 minutes x 2 measures x 4 quarters). The Hybrid HWR and Hybrid HWM measures use both claims-based data and EHR data, specifically, a set of core clinical data elements consisting of vital signs and laboratory test information and patient linking variables collected from hospitals' EHR systems. We do not estimate any burden to hospitals to report the claims-based portion of these measures because these data are already reported to the Medicare program for payment purposes. However, we do expect that hospitals will experience burden in reporting the EHR data.

In the CY 2025 OPPS/ASC proposed rule, we are proposing that for both the Hybrid HWR and Hybrid HWM measures, the FY 2026 payment determination (based on performance data from July 1, 2023 through June 30, 2024), the submission of core clinical data elements (CCDEs) and linking variables would remain voluntary. We propose that for the FY 2027 payment determination and subsequent years, the submission of CCDEs and linking variables become mandatory (89 FR 59502). Because our burden estimates assume that all hospitals will participate during the voluntary reporting period in order to not underestimate the burden on participating hospitals, we do not anticipate any changes to burden as a result of this proposal, if finalized.

We estimate the annual burden for all 3,050 IPPS hospitals to be 4,067 hours (1.33 hours/hospital x 3,050 IPPS hospitals) at a cost of $211,955 (4,067 hours x $52.12/hour). The total annual burden for all 1,500 non-IPPS hospitals is estimated to be 2,000 hours (1.33 hours/hospital x 1,500 non-IPPS hospitals) at a cost of $104,240 (2,000 hours x $52.12/hour).

Table 6. Estimated Burden for Hybrid Measure Reporting and Submission Requirements for the FY 2027 through FY 2029 Payment Determination Years

Hybrid Measure Reporting	*Estimated time per record (minutes)*	*Number reporting quarters per year*	*Number of hospitals reporting*	*Average number records per hospital per quarter*	*Annual burden (hours) per hospital*	*Total Annual Hours for all hospitals*
FY 2027 through FY 2029 Payment Determination Years						
Hybrid HWR measure (IPPS Hospitals)	10	4	3,050	1	0.67	2,033
Hybrid HWR measure (Non-IPPS Hospitals)	10	4	1,500	1	0.67	1,000
Subtotal Burden Hours						**3,033**
Hybrid HWM measure (IPPS Hospitals)	10	4	3,050	1	0.67	2,033
Hybrid HWM measure (Non-IPPS Hospitals)	10	4	1,500	1	0.67	1,000
Subtotal Burden Hours						**3,033**
Total Burden Hours						**6,067**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$316,195**

(h) Process Measure Reporting and Submission Burden

We are not making any changes to the reporting or submission requirements for the process measures in the FY 2025 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2026 payment determination, we currently estimate the information collection burden associated with the Screening for Social Drivers of Health measure to be 2 minutes (0.033 hours) per patient. We also currently estimate the information collection burden for both reporting measure data for the Screening for Social Drivers of Health measure as well as the Screen Positive Rate for Social Drivers of Health measure to be 10 minutes (0.167 hours) per measure per hospital annually.

For the Screening for Social Drivers of Health measure, hospitals are able to collect data and report the measure via multiple methods. We believe the Outcome and Assessment Information Set (OASIS), which is currently used in the Home Health Quality Reporting Program, is a reasonable comparison for estimating the information collection burden for the Screening for Social Drivers of Health measure due to analogous assessment of patient-level need. OASIS is a core standard data assessment that home health agencies integrate into their own patient-specific, comprehensive assessment to identify each patient's need for home care that meets the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For OASIS, the currently approved information collection burden under OMB control number 0938-1279 is estimated to be 0.3 minutes per data element (18 seconds). For the five health related social needs domains screened for by the Social Drivers of Health measure, we estimate a total of 2 minutes (0.033 hours) per patient to conduct this screening.

We believe that the cost for beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $24.04/hr. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices identifies the approach for valuing time when individuals undertake activities on their own time.[4] To derive the costs for beneficiaries, a measurement of the usual weekly earnings of wage and salary workers of $1,118, divided by 40 hours to calculate an hourly pre-tax wage rate of $27.95/hr.[5] This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 14 percent calculated by comparing pre- and post-tax income,[6] resulting in the post-tax hourly wage rate of $24.04/hr. 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.

Based on the most recent information collected by the American Hospital Association,[7] we estimate approximately 18,765,000 patients (31,555,807 total admissions in U.S. community hospitals x 3,050 IPPS hospitals ÷ 5,129 total U.S. community hospitals) will be screened annually across all participating IPPS hospitals and approximately 9,230,000 patients (31,555,807 total admissions in U.S. community hospitals x 1,500 non-IPPS hospitals ÷ 5,129 total U.S. community hospitals). We previously estimated approximately 19,250,000 and 8,250,000 patients would be screened in IPPS and non-IPPS hospitals, respectively, based on prior year data from the American Hospital Association which reported 31,393,318 total admissions in 5,139 total U.S. community hospitals. For the CY 2025 reporting period and subsequent years, we estimate a total annual burden of 625,500 hours (18,765,000 patients x 0.033 hours) at a cost of $15,037,020 (625,500 hours x $24.04/hour) across all IPPS hospitals. We also estimate a total annual burden of 307,667 hours (9,230,000 patients x 0.033 hours) at a cost of $7,396,315 (307,667 hours x $24.04/hour) across all non-IPPS hospitals.

Measure data aggregated at the hospital level will be submitted via the HQR System annually. Similar to the currently approved data submission and reporting burden estimate for eCQMs in the Hospital IQR Program reported via the HQR System, we estimate a burden of 10 minutes per hospital response to transmit the measure data. We estimate that during the voluntary period, 50 percent of hospitals will submit data. For the CY 2025 reporting period and subsequent years, we estimate a total annual burden for all IPPS hospitals of 509 hours (0.1667 hours x 3,050 IPPS hospitals) at a cost of $26,529 (509 hours x $52.12/hour). We also estimate a total annual burden for all non-IPPS hospitals of 250 hours (0.1667 hours x 1,500 non-IPPS hospitals) at a cost of $13,030 (250 hours x $52.12/hour).

For the Screen Positive Rate for Social Drivers of Health measure, hospitals will be required to report on an annual basis the number of patients who screen positive for one or more of the five domains divided by the total number of patients screened (reported as five separate rates). For this measure, we estimate only the additional burden for a hospital reporting this measure via the HQR System since patients will not need to provide any additional information for this measure.

[4] https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework.
[5] https://www.bls.gov/news.release/pdf/wkyeng.pdf. Accessed January 1, 2024.
[6] https://www.census.gov/library/stories/2023/09/median-household-income.html. Accessed January 2, 2024.
[7] https://www.aha.org/statistics/fast-facts-us-hospitals

For the CY 2025 reporting period and subsequent years, we estimate a total annual burden estimate for all participating IPPS hospitals of 509 hours (0.1667 hours/measure x 3,050 IPPS hospitals) at a cost of $26,529 (509 hours x $52.12/hour). We also estimate a total annual burden estimate for all non-IPPS hospitals of 250 hours (0.1667 hours/measure x 1,500 non-hospitals) at a cost of $13,030 (250 hours x $52.12/hour).

Table 7. Estimated Burden for the Process Measures Reporting and Submission Requirements for the FY 2027 through FY 2029 Payment Determination Years

Process Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of respondents***	***Average number records per respondent per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all respondents***
FY 2027 through FY 2029 Payment Determination Years						
Screening for Social Drivers of Health measure (Survey) (Patients in IPPS Hospitals)	0.033	1	18,765,000	1	205.1	625,500
Screening for Social Drivers of Health measure (Reporting) (IPPS Hospitals)	10	1	3,050	1	0.167	509
Screening for Social Drivers of Health measure (Survey) (Patients in Non-IPPS Hospitals)	0.033	1	9,230,000	1	205.1	307,667
Screening for Social Drivers of Health measure (Reporting) (Non-IPPS Hospitals)	10	1	1,500	1	0.167	250
Subtotal Burden Hours						**933,925**
Screen Positive Rate for Social Drivers of Health measure (IPPS Hospitals)	10	1	3,050	1	0.167	509
Screen Positive Rate for Social Drivers of Health measure (Non-IPPS Hospitals)	10	1	1,500	1	0.167	250
Subtotal Burden Hours						**759**
Total Burden Hours						**934,684**
Total Burden @ Average Individual labor rate ($24.04/hr)						**$22,433,327**
Total Burden @ Medical Records Specialist labor rate ($52.12hr)						**$79,118**

(i) Patient-Reported Outcomes-Based Performance Measure Reporting and Submission Burden

We are not making any changes to the reporting or submission requirements for PRO-PM measures in the FY 2025 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2026 payment determination, we continue to estimate the burden per respondent to complete the pre-operative and post-operative questionnaires is 7.25 minutes (0.121 hours). For the data submission which is reported via the HQR System, we continue to estimate a burden of 10 minutes (0.167 hours) per response.

The Hospital-Level THA/TKA PRO-PM uses four sources of data for the calculation of the measure: (1) 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.

Hospitals have multiple options for when and how they collect PRO data so they can 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 can include completion of the pre-operative surveys using electronic devices (such as an iPad or tablet), pen and paper, mail, phone call, or through the patient's 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 can include completion of the post-operative survey using email, mail, phone, or through the patient portal. Use of multiple modes can increase response rates as it allows for different patient preferences.

For Hospital-Level THA/TKA PRO-PM data, hospitals are able to submit data during two voluntary periods, followed by a mandatory period for eligible elective procedures occurring July 1, 2025 through June 30, 2026, impacting the FY 2028 payment determination and for subsequent years. Participating hospitals need to submit data twice (pre-operative data and post-operative data). For the purposes of calculating collection of information-related burden, we estimate that during the voluntary periods, 50 percent of hospitals will submit data, and will do so for 50 percent of THA/TKA patients. We estimate during the mandatory period, hospitals will submit for 100 percent of patients. While hospitals are required 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.

As previously discussed, we believe that the cost for beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $24.04/hr. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework

and Best Practices identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for beneficiaries, a measurement of the usual weekly earnings of wage and salary workers of $1,118, divided by 40 hours to calculate an hourly pre-tax wage rate of $27.95/hr. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 14 percent calculated by comparing pre- and post-tax income, resulting in the post-tax hourly wage rate of $24.04/hr. 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 estimation purposes, we assume that most hospitals will likely undertake PRO data collection through a screening tool incorporated into their EHR or other patient intake process. We estimate that approximately 330,000 THA/TKA procedures occur in the inpatient setting each year, and that many patients could complete both the pre-operative and post-operative questionnaires, although 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. Due to the voluntary and mandatory performance periods occurring across CY-based reporting periods, we have included Table 6 below to allow for easier understanding of how many procedures (and therefore how many surveys) are estimated to be conducted during each reporting period. For the second voluntary reporting period, we assume 82,500 patients will complete the survey (330,000 patients x 50 percent x 50 percent of hospitals) for a total of 9,969 hours annually (82,500 respondents x 0.121 hours) at a cost of $239,649 (9,969 hours x $24.04/hour) across all participating IPPS and non-IPPS hospitals. Beginning with mandatory reporting for the FY 2028 payment determination, we estimate a total of 39,875 hours (330,000 patients x 0.121 hours) at a cost of $958,595 (39,875 hours x $24.04/hour) across all IPPS and non-IPPS hospitals.

We are not able to accurately distinguish the number of procedures that take place in IPPS hospitals from those conducted in non-IPPS hospitals. As a result, we combine the burden associated with completion of the pre-operative and post-operative surveys in Table 8.

Table 8. Estimated Number of THA/TKA PRO-PM Surveys Conducted in the CY 2023 through CY 2026 Reporting Periods

Reporting Period	Performance Period	Number of Procedures	Minutes per Survey	Burden Hours	Total Burden
CY 2023	1st Voluntary Period	20,625	7.25	2,492	**2,492**
CY 2024	1st Voluntary Period	20,625	7.25	2,492	**7,477**
CY 2024	2nd Voluntary Period	41,250	7.25	4,984	
CY 2025	2nd Voluntary Period	41,250	7.25	4,984	**24,922**
CY 2025	Mandatory Period	165,000	7.25	19,938	
CY 2026	Mandatory Period	330,000	7.25	39,875	**39,875**

For each of the two voluntary reporting periods, we estimate that each hospital will spend 20 minutes (0.33 hours) annually (10 minutes x 2 surveys) to collect and submit the data via this tool. We estimate a resulting burden for all participating IPPS hospitals of 509 hours (0.33 hours x 3,050 IPPS hospitals x 50 percent) at a cost of $26,529 (509 hours x $52.12/hour) and a burden for all participating non-IPPS hospitals of 250 hours (0.33 hours x 1,500 non-IPPS hospitals x 50 percent) at a cost of $13,030 (250 hours x $52.12/hour). Beginning with mandatory reporting for the FY 2028 payment determination, we estimate a total annual burden of 1,017 hours (0.33 hours x 3,050 IPPS hospitals) at a cost of $53,006 (1,017 hours x $52.12/hour) for all IPPS hospitals and a total annual burden of 500 hours (0.33 hours x 1,500 non-IPPS hospitals) at a cost of $26,060 (500 hours x $52.12/hour).

Table 9. Estimated Burden for PRO-PM Measure Reporting and Submission Requirements for the FY 2027 through FY 2029 Payment Determination Years

PRO-PM Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of respondents***	***Average number records per respondent per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all respondents***
FY 2027 Payment Determination						
IPPS and Non-IPPS Hospitals (Survey; Voluntary)	7.25	N/A	41,250	N/A	2.22	4,984
IPPS and Non-IPPS Hospitals (Survey; Mandatory)	7.25	N/A	165,000	N/A	4.43	19,938
IPPS Hospitals (Voluntary Reporting)	10	1	1,525	1	0.167	254
IPPS Hospitals (Mandatory Reporting)	10	1	3,050	1	0.167	509
Non-IPPS Hospitals (Voluntary Reporting)	10	1	750	1	0.167	125
Non-IPPS Hospitals (Mandatory Reporting)	10	1	1,500	1	0.167	250
Total Burden Hours						**26,059**
Total Burden @ Average Individual labor rate ($24.04/hr)						**$599,122**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$59,321**
FY 2028 through FY 2029 Payment Determination Years						
IPPS and Non-IPPS Hospitals (Survey)	7.25	N/A	330,000	N/A	8.86	39,875
IPPS Hospitals (Reporting)	10	2	3,050	1	0.33	1,017
Non-IPPS Hospitals	10	2	1,500	1	0.33	500

(Reporting)						
Total Burden Hours						**41,392**
Total Burden @ Average Individual labor rate ($24.04/hr)						**$958,595**
Total Burden @ Medical Records Specialist labor rate ($52.12/hr)						**$79,066**

(j) Burden for Validation of Hospital IQR Program Measure Data, Population and Sampling for Ongoing Measure Sets, and Reviewing Reports for Claims-Based Measure Sets

We are not making any changes to the information collection requirements for eCQM validation, population and sampling of ongoing measure sets, or reviewing of reports for claims-based measure sets in the FY 2025 IPPS/LTCH PPS final rule. As shown in Table 3 for the FY 2026 payment determination, we continue to estimate the information collection burden associated with eCQM validation for CY 2024 reporting period/FY 2027 payment determination and subsequent years to be 10 minutes (0.167 hours) per record for the pool of 400 hospitals selected and assume each selected hospital will submit 8 cases each year. We also continue to estimate the information collection burden associated with population and sampling of ongoing measure sets to be 15 minutes (0.25 hours) per record per quarter and assume each hospital will report four records for four quarters each year. Lastly, we continue to estimate the information collection burden associated with reviewing reports for claims-based measure sets to be 60 minutes (1 hour) per record per quarter and assume each hospital will report one record for four quarters each year.

We estimate the information collection burden per hospital associated with eCQM validation of CY 2024 data impacting the FY 2027 payment determination and for subsequent years to be 2,133 hours across the 400 IPPS hospitals selected for eCQM validation (0.167 hours × 4 quarters × 8 cases × 400 IPPS hospitals) at a cost of $11,189 (2,133 hours x $52.12/hour).

We estimate the information collection burden per hospital associated with population and sampling of ongoing measure sets to be 4 hours (15 minutes/record/quarter x 4 records x 4 quarters) at a cost of $208 (4 hours x $52.12/hour). For all 4,550 IPPS and non-IPPS hospitals, we estimate a total annual burden of 18,200 hours (4 hours x 4,550 hospitals) at a cost of $948,584 (18,200 hours x $52.12/hour).

We estimate the information collection burden per hospital associated with reviewing reports for claims-based measure sets to be 4 hours (60 minutes/quarter x 4 quarters) at a cost of $208 (4 hours x $52.12/hour). For all 4,550 hospitals (IPPS and non-IPPS), we estimate a total annual burden of 18,200 hours (4 hours x 4,550 hospitals) at a cost of $948,584 (18,200 hours x $52.12/hour).

In the FY 2025 IPPS/LTCH PPS final rule, we are updating the scoring methodology for eCQM validation, replacing the existing combined validation score for eCQMs and chart-abstracted measures with two separate validation scores for chart-abstracted measures and eCQMs beginning with the FY 2028 payment determination, and removing the requirement that hospitals must submit 100 percent of eCQM records to pass validation beginning with CY 2025 eCQM data affecting the FY 2028 payment determination. We also finalized the proposal to no longer require hospitals to resubmit medical records as part of their request for reconsideration of

validation, beginning with CY 2025 discharges affecting the FY 2028 payment determination. Changes to the scoring methodology and validation score do not affect burden as neither the amount of data nor frequency of data submission is impacted. Removal of the requirement that hospitals must submit 100 percent of eCQM records to pass validation does not affect burden, as the policy to implement eCQM validation scoring will still require hospitals to submit the same number of requested medical records to validate the accuracy of eCQM data (the extent to which data abstracted from the submitted medical record matches the data submitted in the QRDA I file). Lastly, 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 change in policy to no longer require hospitals to resubmit medical records as part of their request for reconsideration of validation will not affect burden (75 FR 50411).

(k) Burden Associated with Completion of Forms

Time estimates for activities other than chart-abstraction, including completion of the forms listed in section B.1.b, routine reporting of population and sampling numbers for ongoing chart-abstracted measures, and review of reports were made in consultation with our Hospital IQR Program support contractor, which is responsible for routine interface with hospitals and QIOs regarding Hospital IQR Program requirements. We define "all other forms used in the data collection process" as the forms listed below. As shown in Table 3 and consistent with estimates in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49762), we continue to estimate a burden of 15 minutes (0.25 hours) per hospital to complete applicable forms.

Other than the DACA form, the forms listed in section B.1.b would not be filled out by hospitals on a regular basis. Because the CMS Quality Reporting Program ECE Request Form would be used across eleven quality programs (Hospital IQR Program, Hospital Outpatient Quality Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Hospital VBP Program, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, Rural Emergency Hospital Quality Reporting Program, and End Stage Renal Disease Quality Incentive Program), we have included a burden calculation using this form as an example of "all other forms" within this PRA package. This form is intended to be submitted by participants only in the event of an extraordinary circumstance or disaster if they seek an exception from data reporting requirements due to such extraordinary circumstance. For example, in CY 2022, 206 ECE requests were submitted by hospitals for an exception from reporting requirements in the Hospital IQR Program. Based on our estimation of 15 minutes to submit the ECE Request Form, the total burden calculation for the submission of 206 ECE Request Forms was 3,090 minutes (or 52 hours) across 3,050 IPPS hospitals. Note that non-IPPS hospitals do not need this form because they participate in quality data reporting on a voluntary basis. We were conservative in our estimate (provided in Table 3 above) of 1,138 hours across all IPPS and non-IPPS hospitals, thus this 52 hours ECE Request Form burden estimation is accounted for in that figure.

We estimate the information collection burden per hospital associated with completing all other forms used in the data collection process to be $13.03 (0.25 hours x $52.12/hour). For all 4,550 IPPS and non-IPPS hospitals, we estimate a total annual burden of 1,138 hours (0.25 hours x 4,550 hospitals) at a cost of $59,287 (1,138 hours x $52.12/hour).

Beginning with the FY 2025 program year, we are accounting for the burden associated with the Measure Exception Form for NHSN HAI Data Submission under OMB control number 0938-1352 (expiration date November 30, 2025) 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 the burden associated with this form to be 40 hours annually (0.167 hours x 240 hospitals) at a cost of $2,085 (40 hours x $52.12). After subtracting this burden from the total burden of 1,138 hours at a cost of $59,287 for all forms under OMB control number 0938-1022, we estimate a revised total annual burden of 1,098 hours at a cost of $57,202.

(l) Claims-Based Measure Burden

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

(m) Survey Measure Burden

The information collection requirements associated with HCAHPS Survey measure are currently approved under OMB control number 0938-0981, which expires January 31, 2025. As a result, the policy to require data collection for these measures does not influence our burden calculations.

(n) Burden Estimate Summary

As shown in Tables 10 and 11, in summary, under OMB control number 0938-1022, we estimate a total annual information collection burden decrease for 4,550 hospitals (IPPS and non-IPPS) of 6,874 hours associated with our finalized policies and updated burden estimates described above and a total cost decrease related to this information collection of $821,773 (which also reflects use of updated hourly wage rates as previously discussed), from the CY 2025 reporting period/FY 2027 payment determination through the CY 2028 reporting period/FY 2030 payment determination, compared to our currently approved information collection burden estimates. The tables below summarize the total burden changes for each respective FY payment determination compared to our currently approved information collection burden estimates (the columns in each table for the FY 2030 payment determination reflects the cumulative burden changes).

Table 10. Summary of Annual Burden Hour Estimates for the FY 2026 through FY 2030 Payment Determination Years

	ANNUAL BURDEN HOURS									
Information Collection	**FY2026**	**Difference from Currently Approved**	**FY2027**	**Difference from Currently Approved**	**FY2028**	**Difference from Currently Approved**	**FY2029**	**Difference from Currently Approved**	**FY2030**	**Difference from Currently Approved**
Chart Abstraction										
IPPS	1,220,000	-40,000	1,220,000	-40,000	1,220,000	-40,000	1,220,000	-40,000	1,220,000	-40,000
Non-IPPS	36,200	0	36,200	0	36,200	0	36,200	0	36,200	0
Hybrid Measures										
IPPS	4,067	-133	4,067	-133	4,067	-133	4,067	-133	4,067	-133
Non-IPPS	2,000	200	2,000	200	2,000	200	2,000	200	2,000	200
Structural Measures										
IPPS	763	-26	1272	484	1272	484	1272	484	1272	484
Non-IPPS	375	38	625	288	625	288	625	288	625	288
Reporting eCQMs										
IPPS	12,200	-400	12,963	-426	17,030	3,642	19,063	5,675	23,089	9,701
Non-IPPS	6,000	+600	6,375	638	8,375	2,638	9,375	3,638	11,375	5,638
Process Measures										
IPPS	626,518	-16,199	626,518	-16,199	626,518	-16,199	626,518	-16,199	626,518	-16,199
Non-IPPS	308,167	32,717	308,167	32,717	308,167	32,717	308,167	32,717	308,167	32,717
PRO-PM Measures										
IPPS	7,986	-16	25,685	-25	40,892	-33	40,892	-33	40,892	-33
Non-IPPS	250	25	375	38	500	50	500	50	500	50
Population and sampling for the ongoing measure sets	18,200	200	18,200	200	18,200	200	18,200	200	18,200	200
Review reports for claims-based measure sets	18,200	200	18,200	200	18,200	200	18,200	200	18,200	200
eCQM Validation	2,133	0	2,133	0	2,133	0	2,133	0	2,133	0
All other forms used in the data collection process	1,098	-27	1,098	-27	1,098	-27	1,098	-27	1,098	-27
TOTAL	**2,264,157**	**-22,821**	**2,283,878**	**-22,045**	**2,305,276**	**-15,974**	**2,308,310**	**-12,940**	**2,314,336**	**-6,914**

Table 11. Summary of Annual Burden Cost Estimates for the FY 2026 through FY 2030 Payment Determination Years*

	ANNUAL BURDEN COST									
Information Collection	**FY2026**	**Difference from Currently Approved**	**FY2027**	**Difference from Currently Approved**	**FY2028**	**Difference from Currently Approved**	**FY2029**	**Difference from Currently Approved**	**FY2030**	**Difference from Currently Approved**
Chart Abstraction										
IPPS	$63,586,400	($2,084,800)	$63,586,400	($2,084,800)	$63,586,400	($2,084,800)	$63,586,400	($2,084,800)	$63,586,400	($2,084,800)
Non-IPPS	$1,886,744	$0	$1,886,744	$0	$1,886,744	$0	$1,886,744	$0	$1,886,744	$0
Hybrid Measures										
IPPS	$211,955	($6,949)	$211,955	($6,949)	$211,955	($6,949)	$211,955	($6,949)	$211,955	($6,949)
Non-IPPS	$104,240	$10,424	$104,240	$10,424	$104,240	$10,424	$104,240	$10,424	$104,240	$10,424
Structural Measures										
IPPS	$39,776	($1,295)	$66,305	$25,234	$66,305	$25,234	$66,305	$25,234	$66,305	$25,234
Non-IPPS	$19,545	$1,981	$32,575	$15,011	$32,575	$15,011	$32,575	$15,011	$32,575	$15,011
Reporting eCQMs										
IPPS	$635,864	($20,848)	$675,606	($22,177)	$887,578	$189,795	$993,538	$295,755	$1,203,373	$505,617
Non-IPPS	$312,720	$31,272	$332,265	$33,253	$436,505	$137,493	$488,625	$189,613	$592,865	$293,853
Process Measures										
IPPS	$15,090,078	($390,315)	$15,090,078	($390,315)	$15,090,078	($390,315)	$15,090,078	($390,315)	$15,090,078	($390,315)
Non-IPPS	$7,422,375	$787,921	$7,422,375	$787,921	$7,422,375	$787,921	$7,422,375	$787,921	$7,422,375	$787,921
PRO-PM Measures										
IPPS**	$206,276	($824)	$638,898	($1,269)	$1,011,601	($1,720)	$1,011,601	($1,720)	$1,011,601	($1,720)
Non-IPPS	$13,030	$1,303	$19,545	$1,981	$26,060	$2,606	$26,060	$2,606	$26,060	$2,606
Population and sampling for the ongoing measure sets	$948,584	$10,424	$948,584	$10,424	$948,584	$10,424	$948,584	$10,424	$948,584	$10,424
Review reports for claims-based measure sets	$948,584	$10,424	$948,584	$10,424	$948,584	$10,424	$948,584	$10,424	$948,584	$10,424
eCQM Validation	$111,189	$0	$111,189	$0	$111,189	$0	$111,189	$0	$111,189	$0
All other forms used in the data collection process	$57,202	-$1,433	$57,202	-$1,433	$57,202	-$1,433	$57,202	-$1,433	$57,202	-$1,433
TOTAL	**$91,594,562**	**($1,652,871)**	**$92,132,545**	**($1,612,451)**	**$92,827,975**	**($1,296,048)**	**$92,986,055**	**($1,137,968)**	**$93,300,130**	**($823,703)**

* Cost estimates are based on updated wage rates. Differences from currently approved burden account for updating estimates of currently approved hours to the new wage rates.
** Includes burden associated with surveys completed by patients receiving care at non-IPPS hospitals (see Section B.12.i)

(o) Information Collection Instruments/Instructions

In addition to the administrative forms discussed in section B.1.b, the Hospital IQR Program uses three additional information collections forms: the Maternal Morbidity Structural Measure Form, the eCQM Denominator Declaration Form, and the Population and Sampling Form. The following forms will be revised and submitted with this PRA package:

- The Hospital Quality Reporting Data Accuracy and Completeness Acknowledgement form is being resubmitted to reflect an added bullet for "data elements for the patient reported outcomes performance measure."
- The Hospital Compare Request Form for Withholding/Footnoting Data for Public Reporting is being resubmitted to add new measures and make updates to table grouping and ordering.
- The CMS Quality Reporting Program APU Reconsideration Request Form is being resubmitted to update instruction details in the "chart-abstracted validation" section.
- The CMS Hospital IQR Program Validation Review for Reconsideration Request Form is being resubmitted to update guidance related to submitting validation reconsideration medical records that removes duplicative effort.
- The CMS Quality Program Extraordinary Circumstances Exceptions (ECE) Request Form is being resubmitted to (1) clarify and align instructional language, (2) add the Rural Emergency Hospital Quality Reporting Program, and (3) reflect current program measure inclusions.
- The representation of the Maternal Morbidity Structural Measure data collection tool which reflects the removal an obsolete instruction clarification is being resubmitted.
- The eCQM Denominator Declaration form is being resubmitted to update the screenshot of the data form.
- Documents which visually demonstrate the data entry within the Hospital Quality Reporting Secure Portal for the THA/TKA Patient-Reported Outcome-based Performance Measure, Social Drivers of Health Measures, and Hospital Commitment to Health Equity measure are being added to this package.

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

- Hospital Inpatient Quality Reporting Notice of Participation
- Hospital Value-Based Purchasing (VBP) Program Review and Corrections Form
- Hospital Value-Based Purchasing (VBP) Program Appeal Request Form
- Hospital Value-Based Purchasing (VBP) Program Independent CMS Review Request Form
- Population and Sampling Form
- Hospital Quality Reporting Data Validation Educational Review Form

13. Capital Costs (Maintenance of Capital Costs)

For hospitals that are not currently collecting Hospital-Level THA/TKA PRO-PM data, there will 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 will report data for this measure via CMS' HQR System, we assume some hospitals may elect to submit measure data via a third-party CMS-approved survey vendor, for which there are associated costs. Under OMB control number 0938-0981 for the HCAHPS Survey measure (expiration date January 31, 2025), an estimate of approximately $4,200 per hospital is used to account for these costs.

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 for the validation and quality reporting contracts. Additionally, this program requires three CMS staff at a GS-13 Step 5 level with approximate annual salaries of $133,692 plus benefits (30%) of $40,108 per staff member to operate for an additional cost of $521,400. The total annual cost to the Federal Government is $10,571,400.

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

15. Program or Burden Changes

We previously requested and received approval for total annual burden estimates under this OMB control number for the CY 2025 reporting period/FY 2027 payment determination of 2,305,922 hours at a total cost of approximately $80.7 million as a result of policies finalized in the FY 2024 IPPS/LTCH PPS final rule. Accounting for updated wage rates, the total cost of $80.7 million increases to $93.7 million. For the CY 2025 reporting period/FY 2027 payment determination, based on the policies in the FY 2025 IPPS/LTCH PPS final rule, we estimate a total burden of 2,283,878 hours and $92,132,545 (a decrease of 22,045 hours and $1,612,451 from our estimate in the FY 2024 IPPS/LTCH PPS final rule). This burden estimate also represents a decrease of 3,099 hours and an increase of $11,856,849 from the currently approved burden estimate of 2,286,977 hours and $80,275,696 for the CY 2023 reporting period/FY 2025 payment determination.

The policy in the FY 2025 IPPS/LTCH PPS final rule to adopt the Age Friendly Hospital measure beginning with the FY 2027 payment determination results in an annual burden increase of 759 hours at a cost of $39,559. The policy to increase the number of eCQMs hospitals will be required to report from six to eleven results in an annual burden increase of 15,126 hours at a cost of $788,367. The removal of the Measure Exception Form for NHSN HAI Measures from OMB control number 0938-1022 results in an annual burden decrease of 40 hours and $2,085. Accounting for the impact of the policies in the FY 2025 IPPS/LTCH PPS final rule, our updated estimates of the number of IPPS and non-IPPS hospitals as well as the number of inpatient admissions for the Screening for Social Drivers of Heath measure results in a decrease of 22,759 hours and $1,649,544. The aggregate decrease due to these policies and adjustments is 6,914 hours (-22,759 + 759 + 15,126 - 40) and $823,703 (-$1,649,544 + $39,559 + $788,367 - $2,085) as shown in Tables 10 and 11.

16. Publication/Tabulation Dates

The goal of the data collection is to tabulate and publish hospital-specific data. We will continue to display hospital quality information for public viewing as required by Social Security Act sections 1886(b)(3)(B)(viii)(VII) for the Hospital IQR Program, 1886(o)(10) for the Hospital VBP Program, 1886(p)(6) for the HAC Reduction Program, 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 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 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, are also available to the public as downloadable files at https://data.medicare.gov. Hospital quality data on the Compare tool are currently updated on a quarterly basis. One of the goals of the Hospital IQR 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.

17. Expiration Date

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

18. Certification Statement

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