Supporting Statement – Part A

Collection of Information for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program: CY 2025 OPPS/ASC Final Rule (OMB# 0938-1270; CMS-10530)

A. Background

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

Specifically, CMS has implemented quality measure reporting programs for multiple settings, including for ambulatory surgical centers (ASCs), as authorized by statute, and seeks to achieve overarching priorities and initiatives promoting quality healthcare, such as detailed in the National Quality Strategy[1] and the Meaningful Measures 2.0 Framework.[2] The Meaningful Measures 2.0 Framework 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 calendar year (CY) 2029 payment determination for the ASCQR Program are approved under OMB control number 0938-1270 (expiration date August 31, 2025). This request covers data collection requirements for CYs 2027 through 2030 payment determinations and subsequent years. This revised information collection request includes burden for the Facility Commitment to Health Equity (FCHE) measure, the Screening for Social Drivers of Health (SDOH) measure, and the Screen Positive Rate for SDOH measure.

B. Justification

1. Need and Legal Basis

The Ambulatory Surgical Center Quality Reporting (ASCQR) Program was established under section 1833(t) of the Social Security Act (the Act). A quality reporting program for ASCs was authorized by section 109(b) of the Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006[3] which amended section 1833(i) of the Act. Section 1833(i)(2)(D)

[1] https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy
[2] https://www.cms.gov/medicare/quality/meaningful-measures-initiative/meaningful-measures-20
[3] Pub. L. 109-432

(iv) of the Act states that the Secretary may provide that any Ambulatory Surgical Center (ASC) that does not submit quality measures to the Secretary in accordance with paragraph (7) may incur a 2.0 percentage point reduction to any annual increase provided under the revised ASC payment system for such year.

Section 1833(i)(7)(B) of the Act provides that, ''[e]xcept as the Secretary may otherwise provide,'' the hospital outpatient quality data provisions of subparagraphs (B) through (E) of section 1833(t)(17) of the Act shall apply to ASCs in a similar manner to the manner in which they apply under these paragraphs to hospitals and any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ASC, the setting of an ASC, or services of an ASC, respectively. Section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form, manner, and at a time that the Secretary specifies.

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

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

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

(a) ASCQR Program Measures

The ASCQR Program seeks to collect and publicly report data on quality-of-care measures for the ASC setting. Measure data are submitted via one of four modes: (1) web-based; (2) claims-based; (3) survey-based; and (4) Patient-Reported Outcomes-Based Performance Measures (PRO-PM), as seen in Table 1.

For "web-based" measures, measure data are submitted via one of two web-based tools, depending on the measure. For any structural and process measures reported directly to CMS, ASCs are required to submit measure data via CMS' Hospital Quality Reporting (HQR) system. The COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure is calculated using data submitted via the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) under OMB control number 0920-1317 (expiration date March 31, 2026). 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).[4]

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

As a "survey-based" measure, information for the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey measure is derived through analysis of responses and requires ASCs to administer the survey and submit the survey data to CMS. These survey administration burdens are captured under OMB control number 0938-1240, which expires November 30, 2026.

The Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM) uses four sources of data for the calculation of the measure: (1) PRO data; (2) Medicare claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. We estimate no additional burden associated with use of Medicare claims data, Medicare enrollment and beneficiary data, and U.S. Census Bureau survey data as these data are already collected via other mechanisms. Once ASCs collect the PRO data, it is submitted electronically via the CMS HQR system.

Table 1. ASCQR Program Measures for the CY 2026 Payment Determination and Subsequent Years

Measure Submission Mode and Name	CBE No.
Web-Based Measures	
Patient Burn	N/A†
Patient Fall	N/A†
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	N/A†
All-Cause Hospital Transfer/Admission	N/A†
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	0658
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	N/A†
Normothermia Outcome	N/A
Unplanned Anterior Vitrectomy	N/A
COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)**	3636
Survey-Based Measures	
Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)*	N/A
Patient-Reported Outcomes-Based Performance Measures (PRO PMs)	
Risk-Standardized PRO-PM Following Elective Primary Total Hip	N/A

[4] Pub. L. 99-660.

Measure Submission Mode and Name	CBE No.
Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the Ambulatory Surgical Center (ASC) Setting (THA/TKA PRO-PM)	
Claims-Based Measures	
Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy	2539
Hospital Visits After Orthopedic ASC Procedures	3470
Hospital Visits After Urology ASC Procedures	3366
Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at ASCs	3357

†Measure is no longer endorsed by the Consensus Based Entity (CBE) but was endorsed previously.
*Burden for these measures is accounted for under OMB control number 0938-1240.
**Burden for this measure is accounted for under OMB control number 0920-1317.

(b) Summary of Finalized ASCQR Program Changes

In the CY 2025 OPPS/ASC final rule, we adopted three web-based measures that will impact previously approved burden estimates: (1) the FCHE measure, beginning with the CY 2025 reporting period/CY 2027 payment determination; (2) the Screening for SDOH measure, beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; and (3) the Screen Positive Rate for SDOH measure, beginning with voluntary reporting for the CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. We did not finalize any other measure removals or adoptions, or other policies which will have an impact on previously approved burden estimates.

(c) ASCQR Program Administrative Forms

CMS has implemented procedural requirements that align multiple quality reporting programs, including the ASCQR, Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), Hospital Inpatient Quality Reporting (IQR), PPS-Exempt Cancer Hospital Quality Reporting (PCHQR), and Inpatient Psychiatric Facility Quality Reporting (IPFQR) Programs. These procedural requirements involve submission of forms to comply with hospital and ASC quality program requirements. As a result, many of the forms are used for multiple programs and are included under OMB control number 0938-1022 to reduce administrative burden and the potential for errors when updates are necessary.

The ASCQR Program uses four administrative forms: (1) Extraordinary Circumstances Exception Request form; (2) Reconsideration Request form; (3) Withdrawal of Participation form; and (4) Request Form for Withholding/Footnoting Data From Public Reporting. These forms are completed only on a need-to-use, exception basis and most ASCs will not need to complete any of these forms in a given year. Thus, the burden for providers associated with forms utilized in the ASCQR Program is nominal, if any.

(1) Extraordinary Circumstances Exception (ECE) Request Form

CMS offers a process for ASCs to request exceptions to the reporting of required quality data when an ASC experiences an extraordinary circumstance not within the control of the ASC, such as a natural disaster.

(2) Reconsideration Request form

When CMS determines that an ASC has not met program requirements and has had a 2.0 percentage point reduction in their annual payment update (APU), the ASC may submit a Reconsideration Request to CMS no later than the first business day[5] on or after March 17 of the affected payment year. CMS provides this form online and facilities may submit the form online or by fax.

(3) Withdrawal of Participation Form

Once an ASC submits quality measure data and the submission is accepted, the facility is considered a program regardless of whether it continues to submit quality measure data, until formally withdrawing from the program. To withdraw from the program after submitting quality measure data, an ASC must complete and submit an online withdrawal form by August 31st for the applicable CY.

(4) Request Form for Withholding/Footnoting Data From Public Reporting

ASCs with fewer than 240 Medicare claims and elect to voluntarily participate in quality reporting may elect to have data withheld from public reporting by completing the Request Form for Withholding/Footnoting Data from Public Reporting. Once this form is submitted, data can be withheld for the quarter in which the form is submitted. However, the data will be released on the Provider Data Catalog website at data.cms.gov for subsequent releases unless the ASC submits a new Request Form for Withholding/Footnoting Data from Public Reporting indicating the measure(s) the ASC would like to withhold from public reporting for the period.

2. Information Users

The ASCQR 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 ASCs 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 ASC and the ASC's Medicare claims, and some also include information about how the ASC's data compare relative to the performance of other ASCs. For example, the Facility, State and National (FSN) Report allows ASCs to compare their performance related to a specific measure during a specific timeframe, to the average performance of other ASCs at the state and national levels.

[5] 42 CFR § 416.310(f) All deadlines occurring on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order are extended to the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order.

Information gathered by the program can be utilized by ASCs as metrics for required quality assessment and performance improvement (QAPI) programs under ASC conditions for coverage (CfC). As described in 42 CFR 416.43, these programs must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes and improves patient safety by using quality indicators or performance measures associated with improved health outcome and by the identification and reduction of medical errors.

This information is also available to Medicare beneficiaries, as well as to the general public, to provide information to assist them in making decisions about their health care. ASCQR Program data are published on the data.cms.gov website in a form that allows consumers to review both facility-level and national performance on quality measures selected for use in the ASCQR Program.

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 quality programs, CMS' findings were formally written into the latest triennial National Impact Assessment Report, which was released in 2024.[6]

3. Use of Information Technology

To assist ASCs 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 and to increase the utility of the data provided by the ASCs. As an example, CMS employs the established, free data collection tool, the CMS Abstraction and Reporting Tool (CART) for use in collecting data from paper or electronic medical records for chart-abstracted measures. 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. ASCs have the option of using authorized vendors to transmit the data. CMS has engaged a national support contractor to provide technical assistance with program requirements and to provide education to support program participants.

As reflected by the collection and reporting of quality measures calculated from Medicare claims information and use of web-based tool submission of aggregate data, 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 is 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, and other administrative data in part, this section is not applicable, because these measures are fully

[6] 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.

calculated using data that are reported to the Medicare program for payment purposes. Therefore, no additional information technology will be required of ASCs 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 ASC care. CMS requires ASCs to submit quality measure data for services provided in the ambulatory surgical setting. We prioritize efforts to reduce reporting burden for the collection of quality-of-care information by utilizing electronic data that ASCs may collect for reporting for accreditation purposes.

5. Small Business

Based on industry survey, ASCs have an average of twenty employees. While we are unable to accurately determine the number of ASCs that would be considered small businesses, we believe that the majority would qualify as such. Information collection requirements are designed to allow maximum flexibility, specifically to small ASCs participating in the ASCQR Program.

We provide a help-desk hotline for troubleshooting purposes and 24/7 free information available on the QualityNet website through a Questions and Answers function. These activities can assist ASCs in gathering information for their own quality improvement efforts and for meeting ASCQR Program information collection requirements.

6. Less Frequent Collection

CMS has designed the collection of quality-of-care data to be the minimum necessary for calculation of summary figures to be reliable estimates of individual ASC performance. Under the ASCQR Program, ASCs are required to submit CMS web-, survey-, and claims-based measure data on an annual basis relevant to their reporting period to make payment determinations. 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 for the ASCQR Program.

Table 2. Frequency of Data Submission Under the ASCQR Program by Measure Type

Measure Type	Frequency of Data Submission
NHSN	Quarterly*
Web-based*	Annually
Survey-based	Quarterly
THA/TKA PRO-PM	Annually

*One of this web-based measure type is submitted to the CDC for at least one self-selected week during each month of the reporting quarter, but is aggregated quarterly for applicable CMS quality reporting programs.

Claims-based measures are calculated from Medicare FFS claims data; ASCs submit claims for reimbursement or payment per claims processing timeliness requirements. To collect these measure data less frequently could 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 for this data collection was published on July 22, 2024 (89 FR 59186). Comments received regarding the burden estimates are included in this PRA package. The CY 2025 OPPS/ASC final rule (RIN 0938-AV35) was published on November 27, 2024 (89 FR 93912).

Measures adopted for the ASCQR Program are required by statute to undergo a recognized consensus process. Section 1890A of the Act requires CMS to consider input on the selection of quality and efficiency measures from a multi-stakeholder group convened by the "consensus-based entity." To fulfill this requirement, the Partnership for Quality Measurement 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 quality reporting program 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 (e.g. solicitation of comments).

9. Payment/Gift to Respondent

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

10. Confidentiality

As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted to the extent provided by law. All information collected under the ASCQR 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 ASC-specific data will be made publicly available as mandated by statute.

Data related to the ASCQR 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 ASCQR 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.

12. Burden Estimate (Total Hours & Wages)

(a) Background

In the CY 2025 OPPS/ASC final rule, we adopted three web-based measures that will impact previously approved burden estimates: (1) the FCHE measure, beginning with the CY 2025 reporting period/CY 2027 payment determination; (2) the Screening for SDOH measure, beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination; and (3) the Screen Positive Rate for SDOH measure, beginning with voluntary reporting for the CY 2025 reporting period and mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. We did not finalize any other measure removal or adoptions, or other policies, which will have an impact on previously approved burden estimates.

(b) Burden for the CY 2026 Payment Determination

Our currently approved burden estimates were based on an assumption that 4,809 ASCs would report data to the ASCQR Program. Based on the most recent analysis of the CY 2024 payment determination data, we found that, of the 5,536 ASCs that were actively billing Medicare, 4,196 were required to participate in the ASCQR Program. Of the 1,340 ASCs not required to participate in the program, 279 ASCs did so and met full requirements. On this basis, we estimate that 4,475 ASCs (4,196 + 279) will submit data for the ASCQR Program for the CY 2025 reporting period/CY 2027 payment determination. For the purposes of burden estimation, we assume all activities associated with the ASCQR 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 submission of data to clinical registries and the completion of any of the other applicable forms associated with activities related to the ASCQR Program.

OMB has currently approved 54,756 hours at a cost of $2,813,693 under OMB control number 0938-1270, accounting for information collection burden experienced by approximately 4,809 ASCs for the CY 2026 payment determination. As shown in Table 3, using our updated assumption of 4,475 ASCs and updated wage rates, we estimate a revised baseline burden of 49,576 hours at a cost of $2,745,519 for the CY 2026 payment determination. As previously stated, our burden estimates exclude burden associated with the COVID-19 Vaccination Coverage Among HCP measure under OMB control number 0920-1317 (expiration date March 31, 2026), the OAS CAHPS Survey measure under OMB control number 0938-1240 (expiration date November 30, 2026), and claims-based quality measures, which do not require additional effort or burden from ASCs. We also note that any burden related to claims more generally is accounted for under the Health Insurance Common Claims Form and Supporting Regulations under OMB control number 0938-1197 (expiration date October 31, 2027).

Table 3. Currently Approved Burden Estimates for the ASCQR Program Measure Set and Other Activities for the CY 2026 Payment Determination

Measure Set	***Estimated time per record (minutes) - CY 2026 payment determination***	***Number of reporting quarters per year - CY 2026 payment determination***	***Number of respondents***	***Average number of records per ASC per quarter***	***Annual burden (hours) per ASC***	***Total Burden Hours for CY 2026 payment determination***
Web-Based Measures						
Patient Burn (Reporting)	10	1	4,475	1	0.167	746
Patient Fall (Reporting)	10	1	4,475	1	0.167	746
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	10	1	4,475	1	0.167	746

(Reporting)						
All-Cause Hospital Transfer/Admission (Reporting)	10	1	4,475	1	0.167	746
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	4,475	1	0.167	746
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Chart Abstraction)	2.9	1	4,475	63	3.1	13,814
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Reporting)	10	1	895	1	0.167	149
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Chart Abstraction)	2.9	1	895	63	3.1	2,763
Normothermia Outcome (Reporting)	10	1	4,475	1	0.167	746
Normothermia Outcome (Chart Abstraction)	2.9	1	4,475	63	3.1	13,814
Unplanned Anterior Vitrectomy (Reporting)	10	1	4,475	1	0.167	746
Unplanned Anterior Vitrectomy (Chart Abstraction)	2.9	1	4,475	63	3.1	13,814
Web-Based Measures Subtotal						**49,576**
PRO-PM						
THA/TKA (Patient Survey)*	7.25	0	0	0	0	0
THA/TKA (Reporting)*	10	0	0	0	0	0
PRO-PM Subtotal						**0**
Total Burden Hours						**49,576**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)						**$2,745,519**

*These measures do not begin until the CY 2025 reporting period.

Changes to currently approved burden estimates due to finalized measure adoptions s in the CY 2025 OPPS/ASC final rule are discussed below.

(c) Updated Hourly Wage Rate

The most recent data from the Bureau of Labor Statistics May 2023 National Occupational Employment and Wage Estimates reflects a mean hourly wage of $27.69 per hour for medical

records specialists working in "general medical and surgical hospitals" (SOC 29-2072).[7] We calculated the cost of overhead, including fringe benefits, at 100 percent of the mean hourly wage, consistent with previous years. This is 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 ($27.69 × 2 = $55.38) to estimate total cost is a reasonably accurate estimation method. Accordingly, unless otherwise specified, we will calculate cost burden to hospitals using a wage plus benefits estimate of $55.38 per hour throughout the discussion in this section of this rule for the ASCQR Program.

(d) Web-Based Measures Burden

Certain ASCQR Program measures have the data obtained via chart abstraction and the aggregate results are submitted via a web-based tool. For those measures which address rare, adverse patient-safety events ("Patient Burn," "Patient Fall," "Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant," and All-Cause Hospital Transfer/Admission") based upon the most recent payment determination for CY 2025, we conservatively, i.e., overestimate, for burden estimate purposes that there will be at most one case per month, per web-based measure, per ASC.

For the standard clinical procedure outcome measures (Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients , Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, and Normothermia Outcome) we estimate that each participating ASC will abstract and submit data for the minimum yearly sample size of 63. Thus, we estimate that each participating ASC will spend 2.9 minutes (0.049 hours) per case to collect and submit the data for the minimum required yearly sample size of 63 as designated in the ASCQR Program Specifications Manual. For the mandatory Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients and Normothermia Outcome measures, we estimate an annual burden of 3.1 hours (0.049 hours x 63 cases) for each ASC. We estimate an annual burden of 13,814 hours (4,475 ASCs x 3.1 hours) and $765,019 (13,814 hours x $55.38/hour) for each measure. For the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure, we estimate an annual burden estimate of 2,763 hours (4,475 ASCs x 20 percent x 3.1 hours) at a cost of $153,015 (2,763 hours × $55.38/hour) for all voluntarily participating ASCs.

For the rare adverse surgical event measure, Unplanned Anterior Vitrectomy, we use an overestimated average number of cases reported per ASC to estimate chart-abstraction burden, due to skewed data distribution. Based on the most recent data from the CY 2023 reporting period, we estimate each ASC will be required to abstract data from an average of 7 cases per year. We estimate an annual burden of 0.343 hours (0.049 hours x 7 cases) for each ASC and an annual burden of1,535 hours (4,475 ASCs x 0.343 hours) at a cost of $85,008 (1,535 hours x $55.38/hour) for all ASCs for this measure.

[7] U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed April 29, 2024. Available at: https://www.bls.gov/oes/current/oes292072.htm.

In the CY 2022 OPPS/ASC final rule, we delayed mandatory reporting of the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure beginning with the CY 2025 reporting period/CY 2027 payment determination and maintained reporting for this measure as voluntary. Measure data for these measures are submitted via the HQR system secure portal.

Consistent with prior years, we estimate that each participating ASC will spend 10 minutes per measure per year to collect and submit the data via the HQR system secure portal. For mandatory measures, we estimate a total annual burden estimate for all ASCs of 746 hours (0.167 hours/measure x 4,475 ASCs) at a cost of $41,313 (746 hours x $55.38) per measure. For the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure, we estimate a total annual burden estimate for all voluntarily participating ASCs of 149 hours (4,475 ASCs x 20 percent x 0.167 hours) at a cost of $8,252 (149 hours × $55.38/hour).

In the CY 2025 OPPS/ASC final rule, we adopted the FCHE measure beginning with the CY 2025 reporting period/CY 2027 payment determination. For this measure, ASCs will be required to report an attestation of "yes" or "no" to a set of five domains related to organizational efforts towards health equity once annually using a CMS-designated information system. We estimate the reporting burden associated with this measure to be, on average across all 4,475 ASCs, no more than 10 minutes per ASC per year, as we believe the burden for ASCs to report this measure will be very similar to the burden for hospital inpatient departments to report the same measure once annually under the Hospital IQR Program as approved under OMB control number 0938-1022 (expiration date January 31, 2026). Using an estimate of 10 minutes (or 0.167 hours) per ASC per year, we estimate a total annual burden increase of 746 hours (0.167 hours × 4,475 ASCs) at a cost of $41,313 (746 hours × $55.38/hour) across all ASCs.

In the CY 2025 OPPS/ASC final rule, we adopted the Screening for SDOH measure beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination. For this measure, ASCs will be required to report whether they screened patients for five health-related social needs (HRSN).

ASCs will be able to collect data for the measure using a self-selected screening tool. We expect that most ASCs will likely collect data through a screening tool incorporated into their EHR or other patient intake process. We estimate the information collection burden related to conducting patient screening associated with this measure to be two minutes (0.033 hours) per patient. This is based on the currently approved burden estimate for the Hospital IQR Program under OMB control number 0938-1022 (expiration date January 31, 2026) for the same measure with patient screening for the same HRSN domains and the same frequency of data reporting. To provide an estimate of patient volume for the purposes of calculating the information collection burden associated with this measure, we utilized data derived from the ASC Quality Collaborative (ASCQC) related to ASC patient fall benchmarking data as this metric applies to all patients rather than a subset. Since we expect that ASCs reporting data to the ASCQC will tend to be larger facilities with larger patient populations than non-reporting ASCs, we conservatively estimate that each year approximately 21,322,000 patients ((10,434,676

admissions[8] ÷ 2,190 ASCs reporting) × 4,475 ASCs) with an average of 4,765 patients per ASC (21,322,000 admissions ÷ 4,475 ASCs) will be screened annually when reporting on the measure becomes mandatory. As submission rates among facilities may vary, we conservatively estimate that, for voluntary reporting for the CY 2025 reporting period, 50 percent of ASCs will survey 50 percent of patients, and beginning with the first mandatory reporting period, ASCs will survey and report on 100 percent of patients.

We determine the cost for patients (or their representative) undertaking administrative and other tasks, such as filling out a survey or intake form, using a post-tax wage of $24.49/hour based on the report "Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices," which identifies the approach for valuing time when individuals undertake activities on their own time.[9] To derive the costs for patients (or their representatives), a measurement of the usual weekly earnings of wage and salary workers of $1,139 is divided by 40 hours to calculate an hourly pre-tax wage rate of $28.48/hr.[10] 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,[11] resulting in the post-tax hourly wage rate of $24.49/hour. Unlike our state and private sector wage adjustments, we are not adjusting patient wages for fringe benefits and other indirect costs since the individuals' activities, if any, will occur outside the scope of their employment.

For the CY 2025 voluntary reporting period, we estimate a total burden increase for patients of 177,723 hours (21,322,000 patients × 50 percent response rate × 50 percent of ASCs × 0.033 hours per patient) at a cost of $4,352,436 (177,723 hours × $24.49/hour). Beginning with the CY 2026 mandatory reporting period, we estimate an annual total burden increase for patients of 710,733 hours (21,322,000 patients × 0.033 hours per patient) at a cost of $17,405,851 (710,733 hours × $24.49/hour).

Also in the CY 2025 OPPS/ASC final rule, we adopted the Screen Positive Rate for SDOH measure beginning with voluntary reporting for the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 payment determination.

For this measure, ASCs will be required to report annually the number of patients who screened positive for one or more of the five domains (reported as five separate rates to reflect each of the five HRSN domains) divided by the total number of patients screened. We include the collection burden associated with screening patients in our discussion of the Screening for SDOH measure. Thus, for the Screen Positive Rate for SDOH measure, we estimate only the additional burden

[8] ASC Quality Collaboration, ASC Quality Collaboration Quality Report. Available at https://ascquality.org/benchmarking/. Accessed September 12, 2024.
[9] Office of the Assistant Secretary for Planning and Evaluation, Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices, September 17, 2017. Available at https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework.
[10] Bureau of Labor and Statistics, Usual Weekly Earnings of Wage and Salary Workers, First Quarter 2024. Available at https://www.bls.gov/news.release/pdf/wkyeng.pdf. Accessed April 16, 2024
[11] U.S. Census Bureau, End of Pandemic-Era Expanded Federal Tax Programs Results in Lower Income, Higher Poverty, September 12, 2023. Available at https://www.census.gov/library/stories/2023/09/median-household-income.html. Accessed April 16, 2024.

for ASC reporting via the HQR system since patients will not need to provide, and ASCs will not need to collect, any additional information for this measure. We continue to estimate that, for voluntary reporting for the CY 2025 reporting period, 50 percent of ASCs will submit data, and beginning with the first mandatory reporting period, 100 percent of ASCs will submit data.

For both the Screening for SDOH and Screen Positive Rate for SDOH measures, measure data will be aggregated to the ASC level as a numerator and a denominator and will be submitted via the HQR system annually. Similar to the currently approved burden estimate for other web-based measures, as well as the same measure with the same frequency of data reporting for the Hospital IQR Program under OMB control number 0938-1022, we estimate a burden of 10 minutes (0.167 hours) per measure per ASC to report the measure data. For the CY 2025 voluntary reporting period, we estimate a total collection and reporting burden increase for ASCs of 373 hours (4,475 ASCs × 50 percent of ASCs × 0.167 hours per ASC) at a cost of $20,657 (373 hours × $55.38/hour) for each measure. Beginning with the CY 2026 mandatory reporting period, we estimate a total collection and reporting burden increase for ASCs of 746 hours (4,475 ASCs × 0.167 hours per ASC) at a cost of $41,313 (746 hours × $55.38/hour) for each measure.

Table 4. Estimated Burden for the Web-Based Measure Reporting and Submission Requirements for the CY 2027 through CY 2030 Payment Determination Years

Web-Based Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of respondents***	***Average number records per ASC per quarter***	***Annual burden (hours) per ASC***	***Total Burden Hours for all respondents***
CY 2027 Payment Determination						
Patient Burn (Reporting)	10	1	4,475	1	0.167	746
Patient Fall (Reporting)	10	1	4,475	1	0.167	746
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (Reporting)	10	1	4,475	1	0.167	746
All-Cause Hospital Transfer/Admission (Reporting)	10	1	4,475	1	0.167	746
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	4,475	1	0.167	746
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for	2.9	1	4,475	63	3.1	13,814

Normal Colonoscopy in Average Risk Patients (Chart Abstraction)						
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Reporting)	10	1	895	1	0.167	149
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Chart Abstraction)	2.9	1	895	63	3.1	2,763
Normothermia Outcome (Reporting)	10	1	4,475	1	0.167	746
Normothermia Outcome (Chart Abstraction)	2.9	1	4,475	63	3.1	13,814
Unplanned Anterior Vitrectomy (Reporting)	10	1	4,475	1	0.167	746
Unplanned Anterior Vitrectomy (Chart Abstraction)	2.9	1	4,475	7	0.343	1,535
Facility Commitment to Health Equity (Reporting)	10	1	4,475	1	0.167	746
Screening for SDOH (Voluntary Patient Surveys)	2	1	5,331,691	1	0.033	177,723
Screening for SDOH (Voluntary Reporting)	10	1	2,238	1	0.167	373
Screen Positive Rate for SDOH (Voluntary Reporting)	10	1	2,238	1	0.167	373
Total Burden Hours						**<u>216,512</u>**
Total Burden @ Individual labor rate ($24.49/hr)						**<u>$4,352,436</u>**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)						**<u>$2,148,135</u>**
CY 2028 Payment Determination						
Patient Burn (Reporting)	10	1	4,475	1	0.167	746
Patient Fall (Reporting)	10	1	4,475	1	0.167	746
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (Reporting)	10	1	4,475	1	0.167	746
All-Cause Hospital Transfer/Admission (Reporting)	10	1	4,475	1	0.167	746
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	4,475	1	0.167	746
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	2.9	1	4,475	63	3.1	13,814

(Chart Abstraction)						
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Reporting)	10	1	895	1	0.167	149
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Chart Abstraction)	2.9	1	895	63	3.1	2,763
Normothermia Outcome (Reporting)	10	1	4,475	1	0.167	746
Normothermia Outcome (Chart Abstraction)	2.9	1	4,475	63	3.1	13,814
Unplanned Anterior Vitrectomy (Reporting)	10	1	4,475	1	0.167	746
Unplanned Anterior Vitrectomy (Chart Abstraction)	2.9	1	4,475	7	0.343	1,535
Facility Commitment to Health Equity (Reporting)	10	1	4,475	1	0.167	746
Screening for SDOH (Mandatory Patient Surveys)	2	1	21,322,000	1	0.033	710,733
Screening for SDOH (Mandatory Reporting)	10	1	4,475	1	0.167	746
Screen Positive Rate for SDOH (Mandatory Reporting)	10	1	4,475	1	0.167	746
Total Burden						**750,268**
Total Burden @ Individual labor rate ($24.49/hr)						**$17,405,851**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)						**$2,189,448**

(e) PRO-PM Measures Burden

In the CY 2024 OPPS/ASC final rule, we finalized the adoption of the THA/TKA PRO-PM, beginning with voluntary reporting in the CYs 2025 through 2027 reporting periods, followed by mandatory reporting beginning with the CY 2028 reporting period/CY 2031 payment determination. This measure was previously adopted for the Hospital Inpatient Quality Reporting Program in the FY 2023 IPPS/LTCH PPS final rule with an estimated burden of 7.25 minutes (0.120833 hours) per patient to complete both the pre-operative and post-operative surveys and 10 minutes (0.167 hours) per hospital per response to collect and submit the measure data via the HQR system (87 FR 49386 through 49387). We believe the estimated burden for both patient surveys and data submission will be the same for the ASCQR Program.

The THA/TKA PRO–PM uses four sources of data for the calculation of the measure: (1) patient-reported outcome (PRO) data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. We estimate no additional burden associated with claims data, Medicare enrollment and beneficiary data, and U.S. Census Bureau survey data as these data are already collected via other mechanisms such as Medicare enrollment forms, CMS-1500 form, and U.S. Census Informational Questionnaires. Many ASCs have already incorporated PRO data collection into their workflows. While we did not specify how ASCs

collect PRO data for this measure, ASCs new to collecting PRO data will have multiple options for when and how they will collect these 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 ASC. The modes of PRO data collection can include completion of the pre-operative surveys using electronic devices, pen and paper, mail, telephone, or through a patient portal. Post-operative PRO data collection modes are similar to pre-operative modes. The possible patient touchpoints for post-operative data collection can occur before the follow-up appointment, at the doctor's office, or after the follow-up appointment. If the patient does not or cannot attend a follow-up appointment, the modes of data collection will be completion of the post-operative survey using email, mail, telephone, or through a patient portal. Similar to other surveys like the OAS CAHPS, we believe the use of multiple data collection modes serve to maximize response rates as it allows for different patient preferences.

For the THA/TKA PRO–PM data, ASCs will be able to submit data during three voluntary periods. The first voluntary reporting period will begin in CY 2025 for eligible procedures occurring between January 1, 2025, through December 31, 2025; the second voluntary reporting period will begin with CY 2026 for eligible procedures occurring between January 1, 2026, through December 31, 2026; and the third voluntary reporting period will begin with CY 2027 for eligible procedures occurring between January 1, 2027 through December 31, 2027. Voluntary reporting will be followed by mandatory reporting for eligible elective procedures beginning with the CY 2028 reporting period (occurring between January 1, 2028, through December 31, 2028), impacting the CY 2031 payment determination.

Whether participating in the voluntary reporting period or during subsequent mandatory reporting, ASCs must submit data twice (pre-operative data and post-operative data). For the purposes of calculating burden, we determined the number of ASCs performing these procedures from Medicare FFS claims. Specifically, we estimate that, during the voluntary periods, 50 percent of ASCs that perform at least one THA/TKA procedure will submit data and will do so for 50 percent of THA/TKA patients. For purposes of calculating burden for the mandatory period, we estimate that ASCs will submit for 100 percent of patients. While we finalized a requirement for ASCs 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 ASCs exceed this threshold.

To estimate the burden of information collection for patients completing surveys for this measure, we assume that most ASCs will likely undertake PRO data collection through a screening tool incorporated into their patient intake process. We found that there were 881 ASCs which had an average of 48 THA/TKA paid Medicare FFS claims in CY 2022. Thus, we estimate that approximately 42,288 THA/TKA procedures will occur in ASCs each year, and that many patients could complete both the pre-operative and post-operative questionnaires. However, from our experience with using this measure in the Comprehensive Joint Replacement model, we are also aware that not all patients who complete the pre-operative questionnaire will complete the post-operative questionnaire. For the CY 2025 through 2027 voluntary reporting

periods, we assume 10,584 procedures of which patients can complete a survey (42,288 procedures × 0.50 survey completion rate × 441 ASCs) for a total of 1,279 hours annually (10,584 possible surveys × 0.120833 hours) at a cost of $31,323 (1,279 hours × $24.49) each year. Beginning with mandatory reporting in the CY 2028 reporting period/CY 2031 payment determination, we assume 21,144 procedures of which patients can complete a survey (42,288 procedures × 0.50 survey completion rate × 100 percent ASC participation rate) for a total of 2,555 hours annually (21,144 possible surveys × 0.120833 hours) at a cost of $62,572 (2,555 hours × $24.49) across all ASCs that perform these procedures.

Regarding ASCs' burden related to submitting data for this measure which will be reported via the HQR System, we estimate a burden of 10 minutes per response. ASCs will submit data associated with pre-operative surveys by March 31 of the CY following the CY in which the eligible procedures took place and will submit data associated with post-operative surveys by March 31 of the CY following the CY in which pre-operative data were submitted. Therefore, for the first voluntary reporting period for eligible procedures occurring in CY 2025, pre-operative survey data submission will occur in the first quarter of the CY 2026 reporting period and post-operative survey data submission will occur in the first quarter of the CY 2027 reporting period. For each of the three voluntary reporting periods, we estimate that each ASC will spend 20 minutes (0.33 hours) annually (10 minutes × 2 surveys) to collect and submit the data. For the voluntary CY 2026 reporting period, we estimate a burden for all participating ASCs of 74 hours (0.167 hours × 441 ASCs) at a cost of $4,098 (74 hours × $55.38). For the voluntary CY 2027 and CY 2028 reporting periods, we estimate a burden for all participating ASCs of 147 hours (0.33 hours × 441 ASCs) at a cost of $8,141 (147 hours × $55.38). For the CY 2029 reporting period, we estimate a burden for all participating ASCs of 220 hours [(0.167 hours × 441 ASCs) + (0.167 hours x 881 ASCs)] at a cost of $12,184 (220 hours × $55.38). For the CY 2030 reporting period and subsequent years, we estimate a total of 294 hours (0.33 hours × 881 ASCs) at a cost of $16,282 (294 hours × $55.38).

Table 5. Estimated Burden for the PRO-PM Reporting and Submission Requirements for the CY 2027 through CY 2032 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 Respondent***	***Total Annual hours for all Respondents***
CY 2027 Payment Determination						
THA/TKA (Voluntary Patient Surveys)	7.25	2	10,584	1	0.12083	1,279
Total Burden Hours						**1,279**
Total Burden @ Individual labor rate ($24.49/hr)						**$31,323**
CY 2028 Payment Determination						
THA/TKA	7.25	2	10,584	1	0.12083	1,279

(Voluntary Patient Surveys)						
THA/TKA (Voluntary Measure Reporting)	10	1	441	1	0.167	74
Total Burden Hours						**1,353**
Total Burden @ Individual labor rate ($24.49/hr)						**$31,323**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)						**$4,098**
CY 2029 Payment Determination						
THA/TKA (Voluntary Patient Surveys)	7.25	2	10,584	1	0.12083	1,279
THA/TKA (Voluntary Measure Reporting)	10	2	441	1	0.33	147
Total Burden Hours						**1,426**
Total Burden @ Individual labor rate ($24.49/hr)						**$31,323**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)						**$8,141**
CY 2030 Payment Determination						
THA/TKA (Mandatory Patient Surveys)	7.25	2	21,144	1	0.12083	2,555
THA/TKA (Voluntary Measure Reporting)	10	2	441	1	0.33	147
Total Burden Hours						**2,702**
Total Burden @ Individual labor rate ($24.49/hr)						**$62,572**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)						**$8,141**
CY 2031 Payment Determination						
THA/TKA (Mandatory Patient Surveys)	7.25	2	21,144	1	0.12083	2,555
THA/TKA (Voluntary Measure Reporting)	10	1	441	1	0.167	74
THA/TKA (Mandatory Measure Reporting)	10	1	881	1	0.167	146
Total Burden Hours						**2,775**
Total Burden @ Individual labor rate ($24.49/hr)						**$62,572**
Total Burden @ Medical Records Specialist labor rate ($55.38/hr)						**$12,184**
CY 2032 Payment Determination and Subsequent Years						
THA/TKA (Mandatory Patient Surveys)	7.25	2	21,144	1	0.12083	2,555
THA/TKA (Mandatory Measure Reporting)	10	2	881	1	0.33	294
Total Burden Hours						**2,849**
Total Burden @ Individual labor rate ($24.49/hr)						**$62,572**

Total Burden @ Medical Records Specialist labor rate ($55.38/hr)	**$16,282**

(f) Claims-Based Measure Burden

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

(g) Survey-Based Measure Burden

The information collection requirements associated with the OAS CAHPS survey-based measure is currently approved under OMB control number 0938-1240, which expires November 30, 2026. As a result, the policy to require data collection for the measure does not influence our burden calculations under OMB control number 0938-1270.

(h) Total Burden for the CY 2027 through CY 2030 Payment Determinations

As shown in Table 4, in summary, under OMB control number 0938-1270, we estimate a total annual information collection burden increase for 4,475 ASCs of 696,791 hours associated with our finalized measure adoptions and updated burden estimates described above and a total cost increase related to this information collection of $16,633,758 (which also reflects use of updated hourly wage rates as previously discussed), from the CY 2025 reporting period/CY 2027 payment determination through the CY 2028 reporting period/CY 2030 payment determination, compared to our currently approved information collection burden estimates. The tables below summarize the total burden changes for each respective CY payment determination compared to our currently approved information collection burden estimates (the columns in each table for the CY 2030 payment determination reflects the cumulative burden changes).

Table 5. Total Burden Hours for the CY 2027 through CY 2030 Payment Determinations

Information Collection	CY2027	Difference from Currently Approved	CY2028	Difference from Currently Approved	CY2029	Difference from Currently Approved	CY2030	Difference from Currently Approved
Patient Burn	746	-56	746	-56	746	-56	746	-56
Patient Fall	746	-56	746	-56	746	-56	746	-56
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	746	-56	746	-56	746	-56	746	-56
All-Cause Hospital Transfer/Admission	746	-56	746	-56	746	-56	746	-56
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	14,560	-1149	14,560	-1149	14,560	-1149	14,560	-1149
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	2,912	-230	2,912	-230	2,912	-230	2,912	-230
Normothermia Outcome	14,560	-1149	14,560	-1149	14,560	-1149	14,560	-1149
Unplanned Anterior Vitrectomy	2,281	-13,428	2,281	-13,428	2,281	-13,428	2,281	-13,428
Facility Commitment to Health Equity	746	746	746	746	746	746	746	746
Screening for SDOH	178,096	178,096	711,479	711,479	711,479	711,479	711,479	711,479
Screen Positive Rate for SDOH	373	373	746	746	746	746	746	746
THA/TKA PRO-PM	1,279	0	1,353	0	1,426	0	2,702	0
TOTAL	**217,791**	**163,035**	**751,621**	**696,791**	**751,694**	**696,791**	**752,970**	**696,791**

Table 6. Total Burden Dollars for the CY 2027 through CY 2030 Payment Determinations*

Information Collection	CY2027	Difference from Currently Approved	CY2028	Difference from Currently Approved	CY2029	Difference from Currently Approved	CY2030	Difference from Currently Approved
Patient Burn	$41,313	-$3,073	$41,313	-$3,073	$41,313	-$3,073	$41,313	-$3,073
Patient Fall	$41,313	-$3,073	$41,313	-$3,073	$41,313	-$3,073	$41,313	-$3,073
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	$41,313	-$3,073	$41,313	-$3,073	$41,313	-$3,073	$41,313	-$3,073
All-Cause Hospital Transfer/Admission	$41,313	-$3,073	$41,313	-$3,073	$41,313	-$3,073	$41,313	-$3,073
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	$806,333	-$63,654	$806,333	-$63,654	$806,333	-$63,654	$806,333	-$63,654
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	$161,267	-$12,767	$161,267	-$12,767	$161,267	-$12,767	$161,267	-$12,767
Normothermia Outcome	$806,333	-$63,654	$806,333	-$63,654	$806,333	-$63,654	$806,333	-$63,654
Unplanned Anterior Vitrectomy	$126,322	-$743,655	$126,322	-$743,655	$126,322	-$743,655	$126,322	-$743,655
Facility Commitment to Health Equity	$41,313	$41,313	$41,313	$41,313	$41,313	$41,313	$41,313	$41,313
Screening for SDOH	$4,373,093	$4,373,093	$17,447,164	$17,447,164	$17,447,164	$17,447,164	$17,447,164	$17,447,164
Screen Positive Rate for SDOH	$20,657	$20,657	$41,313	$41,313	$41,313	$41,313	$41,313	$41,313
THA/TKA PRO-PM	$31,323	$0	$35,421	$0	$39,464	$0	$70,713	$0
TOTAL	**$6,531,894**	**$3,539,030**	**$19,630,720**	**$16,633,758**	**$19,634,762**	**$16,633,758**	**$19,666,012**	**$16,633,758**

* 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.

13. Capital Costs (Maintenance of Capital Costs)

For ASCs that are not currently collecting Facility-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 ASCs will report data for this measure via CMS' HQR System, we assume some ASCs may elect to submit measure data via a third-party CMS-approved survey vendor, for which there are associated costs. Under OMB control number 0938-1240 for the OAS CAHPS Survey measure (expiration date November 30, 2026), an estimate of approximately $4,000 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 ASCs and data vendors, calculation of claims-based measures, measure development and maintenance, the provision of ASCs 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, there is one FTE assigned full-time in a lead position to this program. Using a GS-14 step 5 salary, that provides a rough estimate of $157,982 plus benefits (30%) of $47,395 or $205,377 for the federal government labor cost for this program year and subsequent years.

Total estimated cost to the Federal Government for the ASCQR Program is $10,255,377.

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 ASCs 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/CY 2027 payment determination of 54,756 hours at a cost of $2,813,693 as a result of finalized measure adoptions and policies finalized in the CY 2024 OPPS/ASC final rule. Accounting for updated wage rates, the total cost of $2,813,693 increases to $2,992,864. For the CY 2025 reporting period/CY 2027 payment determination, based on the finalized measure adoptions in the CY 2025 OPPS/ASC final rule, we estimate a total burden of 217,791 hours at a cost of $6,531,894 (an increase of 163,035 and $3,539,030 from our estimate in the CY 2024 OPPS/ASC final rule). This burden estimate also represents an increase of 132,880 hours and $4,352,512 from the currently approved burden estimate of 84,911 hours and $2,179,382 for the CY 2024 reporting period/CY 2026 payment determination.

The adoption of the FCHE measure will result in a total estimated burden increase of 746 hours at a cost of $41,313 beginning with the CY 2027 payment determination. The adoption of the Screening for SDOH and Screen Positive Rate for SDOH measures will result in a total estimated burden increase of 711,479 hours at a cost of $17,447,164 and 746 hours at a cost of $41,313, respectively, when mandatory reporting begins for the CY 2028 payment determination. The updated average number of cases reported per ASC for the Unplanned Anterior Vitrectomy measure will result in an estimated decrease of 12,279 hours at a cost of $680,011.

Accounting for the impact of the finalized measure adoptions in the CY 2025 OPPS/ASC final rule and updated burden estimates, our updated estimate of the number of ASCs results in an annual burden decrease of 3,901 hours and $216,021 through the CY 2030 payment determination. The aggregate increase from the CY 2027 payment determination through the CY 2030 payment determination due to these finalized measure adoptions and adjustments is 696,791 hours (-3,901 + 746 + 711,479 + 746 – 12,279) and $16,633,758 (-$216,021 + $41,313 + $17,447,164 + $41,313 - $680,011) as shown in Tables 5 and 6 for the CY 2027 through CY 2030 payment determinations.

16. Publication

As required by authorizing statute, quality measure data have been made publicly available after providing ASCs the opportunity to review their data. The goal of the data collection is to tabulate and publish ASC-specific data. ASC data from these initiatives are currently used to populate CMS' Provider Data Catalog available at: data.cms.gov. 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 will become available on the *QualityNet* website (https://qualitynet.cms.gov). We will also display the approved expiration date prominently on the *QualityNet* website's ASCQR 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.

19. Collections of Information Employing Statistical Methods

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