Supporting Statement – Part A

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

A. Background

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

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

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 82079), CMS amended several of the HPT requirements in order to improve our monitoring and enforcement capabilities by way of improving access to, and the usability of, hospital standard charge information; reduce the compliance burden on hospitals by requiring the use of standard templates and providing technical guidance for display of hospital standard charge information; align, where feasible, certain hospital price transparency requirements and processes with requirements and processes we have implemented in the Transparency in Coverage (TIC) initiative; and make other modifications to our monitoring and enforcement

capabilities that will, among other things, increase its transparency to the public. Specifically, we finalized: (1) definitions for “CMS template”, “estimated allowed amount”, “encode”, and “machine- readable file” (MRF); (2) required hospitals to affirm the accuracy and completeness of data in their MRF; (3) revised and expanded the data elements hospitals must include in the MRF; (4) required hospitals to conform to a CMS template layout and other technical specifications for encoding standard charge information in the MRF; (5) required hospitals to establish and maintain a .txt file and footer as specified by CMS; and (6) revised our enforcement process by updating our methods to assess hospital compliance, requiring hospitals to acknowledge receipt of warning notices, working with health system officials to address noncompliance issues in one or more hospitals that are part of a health system, and publicizing more information about CMS enforcement activities related to individual hospital compliance.

In the CY 2026, OPPS/ASC proposed rule (CMS-1834-P), we propose amendments to the HPT regulations to enhance clarity and standardization in hospital pricing disclosures. Specifically, we propose revisions to § 180.20 to remove the definition for "estimated allowed amount" and add definitions for "median allowed amount", “tenth percentile allowed amount”, and "ninetieth percentile allowed amount", to help ensure greater precision in cost sharing calculations. Furthermore, we propose revisions to § 180.50 to require hospitals, beginning January 1, 2026, to disclose the median, tenth and ninetieth percentile allowed amounts in MRFs when standard charges are based on percentages or algorithms, as well as the count of allowed amounts. We also propose that hospitals should use EDI 835 transaction remittance data to calculate and encode these values, and we propose specific instructions to hospitals with regard to the methodology, including lookback period, that should be used to calculate the median, tenth and ninetieth percentile allowed amounts. We propose revisions to § 180.50(a)(3) to replace the affirmation statement in the MRF with an attestation statement that would also contain new specifications (relative to existing affirmation requirements) and to require hospitals to encode the name of the chief executive officer, president or senior official designated to oversee the encoding of true, accurate and complete data in the MRF. Additionally, we propose adding a standard identifier, specifically the National Provider Identifier (NPI) to the MRFs.

This submission is a reinstatement with change of a previously approved collection. It includes the information collection requirements finalized in the CY 2024 OPPS/ASC final rule with comment period as well as the information collection requirements for the CY 2026 OPPS/ASC proposed rule. We note the previously approved requirements and burden associated with 0938-1369 lapsed due to administrative oversight. Specifically, CMS failed to submit the revisions to 0938-1369 that pertained to the 2024 final rule (CMS-1786-FC) (88 FR 81540). Therefore, CMS has included the finalized burden mentioned in the 2024 OPPS Final Rule (CMS-1786-FC) and the new proposed 2026 OPPS rule in the request for reinstatement.

B. Justification

1. Need and Legal Basis

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

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

The CY2020 HPT Final Rule also established new regulations at 45 CFR 180 Subpart C to provide for monitoring and enforcement activities. These activities may require hospitals to submit documentation to CMS, such as in response to a corrective action plan request, or other data collections necessary for CMS to monitor and assess compliance with the regulatory disclosure requirements.

In the CY2024 OPPS/ASC final rule, CMS finalized requirements to further specify how hospitals make public their standard charges in a machine-readable file under 45 CFR 180.50 and increased CMS' ability to enforce the disclosure requirements under 45 CFR 180.70. CMS revised regulations at 45 CFR 180.50 related to making public hospital standard charges in an MRF. First, we added data elements to be included in the hospital's MRF and required hospitals to conform to a CMS template layout. Second, to enhance automated

access to the MRF, we required that hospitals include a .txt file in the root folder of the public website it selects to host its MRF in the form and manner specified by CMS that includes a standardized set of fields, and a link in the footer on its website that is labeled "Price Transparency" which links directly to the publicly available webpage that hosts the link to the MRF. These requirements were directly responsive to public input received through previous requests for information and recommendations from the HHS Health Federally Funded Research and Development Center (FFRDC) that convened industry experts to explore what data elements would be necessary to improve the public's understanding of the standard charges established by hospitals and to maximize use of the data.

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

In the CY 2026 OPPS/ASC proposed rule, CMS is proposing to require hospitals to report four new data elements when the standard charge is based on a percentage or algorithm – the median allowed amount (which would replace the estimated allowed amount data element), the tenth percentile allowed amount, the ninetieth percentile allowed amount, and the count of allowed amounts. We also propose to require that hospitals use electronic data interchange (EDI) 835 electronic remittance advice (ERA) transaction data to calculate and encode these values, and we propose to require that hospitals abide by specific instructions regarding the methodology, including the lookback period, that should be used to calculate the median, tenth and ninetieth percentile allowed amounts. We believe that the median, tenth and ninetieth percentile allowed amounts would provide greater context and clarity with respect to the payer-specific negotiated charge, would be a better consumer benchmark than the estimated allowed amount, and better enable price estimator tools to develop and estimate an individual's personalized out-of-pocket cost, enabling MRF users to more easily compare such standard charges across hospitals.

We also propose that beginning January 1, 2026, hospitals must attest in their MRF that they have included all applicable standard charge information in accordance with the requirements of 45 CFR 180.50, and the information encoded is true, accurate, and complete as of the date in the file, and the hospital has included all payer-specific negotiated charges in dollars that can be expressed as a dollar amount. For payer-specific negotiated charges that cannot be expressed as a dollar amount in the MRF, or are not knowable in advance, the hospital attests that the payer-specific negotiated charge is based on a contractual algorithm, percentage or formula that precludes the provision of a dollar amount and has provided all necessary information available to the hospital for the public to be able to derive the dollar amount, including, but not limited to, the specific fee schedule or components referenced in such percentage, algorithm or formula. Additionally, we propose that beginning January 1, 2026,

the hospital must encode within the MRF the name of the chief executive officer, president, or senior official designated to oversee the encoding of true, accurate and complete data in the MRF. We believe these proposed requirements will provide the necessary reassurance that hospitals have provided in their MRFs meaningful, accurate information to users of the MRF about their standard charges for health care items and services.

We also propose adding a standard identifier, specifically the National Provider Identifier (NPI) to the MRFs. We believe that adding a standard identifier to the file would advance the comparability of the HPT data with other healthcare data, including health plan transparency data from the Transparency in Coverage (TiC) MRFs.

2. Information Users

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

Hospitals

Hospitals are the only respondents for the purpose of this information collection. This regulation applies to each hospital operating within the United States. As specified in §180.40, a hospital is required to make public both of the following: (1) A machine-readable file containing a list of all standard charges for all items and services as provided in §180.50, and (2) a consumer-friendly list of standard charges for a limited set of shoppable services as provided in §180.60. CMS believes that these two different methods of making hospital standard charges public are necessary to ensure such data is available to consumers where and when it is needed (for example, via integration into price transparency tools, Electronic Health Records (EHRs), and consumer apps), and also directly available and useful to consumers that search for hospital- specific charge information without use of a developed price transparency tool. We believe that requiring hospitals to make public standard charges for shoppable services will increase consumer satisfaction and encourage price comparison, ultimately resulting in decreased out-of- pocket cost to the consumer. Additionally, in 45 CFR 180 Subpart C, CMS enforces the regulatory disclosure requirements and may require hospitals to submit information to CMS in order for CMS to monitor and assess hospital compliance.

Health Care Consumers

CMS intends for consumers to have easier access to health care pricing information in a consumer-friendly format, including payer-specific negotiated charges, de-identified minimum negotiated charges, de-identified maximum negotiated charges, and discounted

cash prices for shoppable services. Consumers will have a better ability to estimate their hospital bills prior to treatment.

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

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

3. Use of Information Technology

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

In the CY2024 OPPS/ASC final rule, CMS modified 45 CFR 180.50 to require that the hospital's machine-readable file conform to the CMS template layout, data specifications, and data dictionary for purposes of making public the standard charge information, and include an expanded set of data elements required under 180.50(b) that CMS determined are necessary to improve the public's understanding of the standard charges the hospital has established. CMS also finalized at new § 180.50(a)(3) that the hospital must include a statement in its machine-readable file affirming that the hospital, to the best of its knowledge and belief, has included all applicable standard charge information in accordance with the requirements of 45 CFR 180.50, and that the information displayed is true, accurate, and complete as of the date indicated in the file.

In the CY2024 OPPS/ASC final rule, CMS finalized at new § 180.50(d)(6) to require that a hospital ensure that the public website it chooses to host the MRF establishes and maintains automated access to the MRF in two specific ways. First, CMS finalized at new §

180.50(d)(6)(i) that the hospital ensure the public website includes a .txt file in the root folder that includes a standardized set of fields including the hospital location name that corresponds to the MRF, the source page URL that hosts the MRF, a direct link to the MRF (the MRF URL), and hospital point of contact information. Second, CMS finalized at new § 180.50(d)(6)(ii) that the hospital includes a link in the footer on its website, including but not limited to the homepage, that is labeled "Hospital Price Transparency" and links directly to the publicly available webpage that hosts the link to the MRF.

In the CY2024 OPPS/ASC final rule, CMS also finalized at new § 180.70(a)(2)(iv), to require an authorized hospital official to submit to CMS a certification to the accuracy and completeness of the standard charge information posted in the MRF at any stage of the monitoring, assessment, or compliance phase. CMS finalized at new § 180.50(a)(3) that the hospital affirm within the MRF the accuracy and completeness of the standard charge information.

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

In the CY 2026 OPPS/ASC proposed rule, CMS proposes to require hospitals to include six additional data elements in the MRF: the median allowed amount; tenth percentile allowed amount; ninetieth percentile allowed amounts; count of allowed amounts; the name of the chief executive officer, president, or senior official designated to oversee the encoding of true, accurate and complete data in the MRF; and NPI, to further improve comparability of the MRF standard charge information.

4. Duplication of Efforts

We anticipate no duplication of efforts for hospitals. The required hospital information collection is distinguishable from other federal efforts, and flexibility is afforded in the CY 2020 HPT Final Rule to allow hospitals to use already existing platforms for making a list of standard charges public to avoid duplication of State and private sector efforts aimed to improve price transparency. Additionally, as specified in the regulation, CMS will deem a hospital as having met the requirements for making public standard charges in a consumer friendly manner if the hospital maintains an internet-based price estimator tool which meets the requirements specified in §180.60.

5. Small Businesses

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

6. Less Frequent Collection

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

As described in the CY 2020 HPT final rule, CMS recognizes that hospital charges may change more frequently than annually and therefore encourages (but does not require) hospitals to update the standard charge data they make public more often, as appropriate, so that the public may have access to the most up-to-date charge information.

7. Special Circumstances

This collection of information does not require any special circumstances.

8. Federal Register/Outside Consultation

Federal Register

A 60-day notice will publish as part of the CY 2026 OPPS/ASC notice (CMS-1834-P) of proposed rulemaking on July 17, 2025 in the Federal Register (90 FR 33476).

Outside Consultation

CMS did not perform any outside consultation specific to this reinstatement. Feedback from hospitals and other interested parties that informed the revisions was obtained during the course of prior rulemaking on these topics and in the regular course of business.

9. Payments/Gifts to Respondents

The HPT regulations at 45 CFR part 180 implement section 2718(e) of the Public Health Service Act that requires each hospital to establish, update, and make public a yearly list of the hospital's standard charges for items and services provided by the hospital. In the CY 2020 final rule, we adopted requirements for hospitals, effective January 1, 2021, to make public their standard charges in two ways: (1) as a comprehensive machine-readable file (MRF); and (2) in a consumer-friendly format. We believe this requirement to make public standard charges for shoppable services will increase consumer satisfaction and encourage price comparison, ultimately resulting in decreased out-of- pocket cost to the consumer.

10. Confidentiality

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

11. Sensitive Questions

There are no sensitive questions associated with this collection.

12. Burden Estimates (Hours & Wages)

In the CY 2024 OPPS/ASC final rule, we increased the number of hospitals we believe to be subject to these requirements from 6,002 to 7,098 which would increase the estimated national burden. In the CY 2020 HPT final rule (84 FR 65591), we estimated that 6,002 hospitals would be subject to the hospital price transparency requirements. To derive the estimated number, we relied on data from the American Hospital Association (AHA).[1] For the 2024 collection of information estimate and this estimate, we used updated hospital numbers based on the publicly available dataset from the Homeland Infrastructure Foundation-Level Data (HIFLD)[2] hospital dataset because the HIFLD dataset compiles a directory of hospital facilities based on data acquired directly from state hospital licensure information and federal sources and updates this data annually. As indicated in the CY 2024 OPPS/ASC proposed and final rules, we believe the HIFLD dataset is more accurate than the AHA Directory. The source data was available in a variety of formats (pdf, tables, webpages, etc.) which is reviewed and geocoded and then converted into a spatial database. To estimate the number of hospitals subject to these requirements, we leveraged the HIFLD hospital dataset to identify 8,013 total hospitals. We then subtracted out 379 hospitals HIFLD identified as "closed" as well as hospitals that are deemed under the regulation to have met requirements (see 45 CFR 180.30) which included 339 federally owned non-military and military hospitals, and 197 state, local, and district run forensic hospitals. We therefore estimated that 2024 OPPS/ASC final rule applied to 7,098 hospitals operating within the United States under the definition of "hospital."

For the CY 2026 OPPS/ASC proposed rule, we updated the number of hospitals estimated to be subject to the HPT requirements using the same methodology as we did in the CY 2024 OPPS/ASC final rule. There were 8,340 hospitals most recently identified in the HIFLD hospital dataset. We subtract 374 hospitals HIFLD identified as "closed" as well as hospitals

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

2 Homeland Infrastructure Foundation-Level Data hospital dataset accessed on April 2, 2025, located at https://hifldgeoplatform.hub.arcgis.com/maps/9e318142490c4884bf74932af437c6c2/about

that are deemed under the regulation to have met requirements which includes 352 federally owned non-military and military hospitals, and 198 state, local, and district run forensic hospitals. We therefore estimate that, for CY 2026 OPPS/ASC proposed rule, 7,416 hospitals would meet the HPT regulation's definition of "hospital" at 45 CFR 180.2.

Finally, we estimated the hourly cost for each labor category cited in the information collections in the CY 2026 OPPS/ASC proposed rule by referencing Bureau of Labor Statistics report on Occupational Employment and Wages (May 2024)[3] in Table 1. We estimate the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage. This is necessarily a rough adjustment, because fringe benefits and overhead costs vary significantly from employer to employer. Nonetheless, we believe that doubling the hourly wage rate to estimate total cost is a reasonably accurate estimation method.

TABLE 1: 2 0 2 4 OCCUPATION TITLES AND WAGE RATES

Occupational Title	Occupation code	Mean hourly wage ($/hr)	Fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
General and Operations Managers	BLS 11-1021	$64.00	$64.00	$128.00
Business Operations Specialists	BLS 13-1000	$43.76	$43.76	$87.52
Network and Computer Systems Administrators	BLS 15-1244	$48.65	$48.65	$97.30

In the CY 2024 OPPS/ASC final rule (88 FR 82151) we estimated the total initial one-time burden to implement the CMS standard template and conform to the data dictionary to be 120 hours (5 hours for a Lawyer + 5 hours for a General and Operations Manager + 80 hours for a Business Operations Specialist + 30 hours for a Network and Computer System Administrator) per hospital with a cost of $10,587.10 ($787.40 for a Lawyer + $590.70 for a General and Operations Manager + $6,406.40 for a Business Operations Specialist + $2,802.60 for a Network and Computer System Administrator) per hospital. The initial one-time national burden was calculated to be $75,147,235.80 dollars ($10,587.10 per hospital × 7,098 hospitals). We still believe this estimate to be an accurate estimate of the one-time burden for a new hospital to implement the CMS standard template and conform to the data dictionary. However, CMS is not aware, currently, of any new hospitals that are beginning operations. We find it challenging to determine the number of new hospitals that are opened each year because distinguishing brand-new hospitals from expansions, new locations, or mergers is inherently

3 U.S. Bureau of Labor Statistics, May 2024 National Occupational Employment and Wage Estimates United States,

Occupational Employment and Wage Statistics. Accessed at https://www.bls.gov/oes/tables.htm

arduous. Many hospitals open satellite facilities or rebrand existing ones under similar names, creating ambiguity in identifying independent entities. Additionally, there is no standardized or centralized database that categorizes hospitals based on their origin, and regulatory processes often overlap for new openings, expansions, and mergers, making it difficult to rely on licensing data alone. Complex ownership structures within healthcare systems further blur the lines between new hospitals and extensions of existing networks. Marketing strategies and naming conventions can also mislead public perception, as hospitals often promote new locations as "new" regardless of their operational independence. Finally, data inconsistencies and delays in reporting further complicated efforts to verify whether a hospital is truly new. Because we find it difficult to determine a new hospital, we still account for the original onetime burden to implement the CMS standard template that we calculated in the CY 2024 OPPS/ASC final rule, but we will no longer account for this one-time burden moving forward.

TABLE 2: SUMMARY OF ONE-TIME BURDEN FOR INFORMATION OF COLLECTIONS IN THE 2024 OPPS/AC FINAL RULE

Regulation section	OMB control no.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Total labor cost of reporting ($)
§ 180.50	0938-1369	7,098	7,098	120	851,760	$70,035,966

In the CY 2026 OPPS/ASC proposed rule, we estimate hospitals would incur an initial one-time cost to update their processes and systems to (1) identify and collect the newly proposed data elements, and (2) encode the standard charge information for the newly proposed data elements in the CMS standard template. To implement the proposed requirements, we estimate that it would take a Business Operations Specialist (BLS 13-1000), on average, 4 hours (at a cost of $87.52 per hour) to develop and update the necessary processes and procedures and develop the requirements to implement the proposed data elements and a General and Operations Managers (BLS 11-1021), on average, 1 hour (at a cost of $128.00 per hour) to review the updates.

Therefore, we believe the one-time burden estimate to be 37,080 hours for all hospitals (5 hours
× 7,416 hospitals) at a cost of $3,545,441.28 (7,416 hospitals × [($87.52 × 4 hours) + ($128.00 × 1 hour)]). We believe the benefits to users of the MRF having this additional information justify the initial one-time burden to hospitals to update their processes and systems to identify and collect the newly proposed data elements and encode the standard charge information for the newly proposed data elements in the CMS standard template.

TABLE 3: SUMMARY OF ONE-TIME BURDEN FOR THE INFORMATION COLLECTIONS IN THE 2026 OPPS/ASC PROPOSED RULE

Regulation section	OMB control no.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Total labor cost of reporting ($)
§ 180.50	0938-1369	7,416	7,416	5	37,080	$3,545,441.28

For the annual burden estimate in the CY 2026 OPPS/ASC proposed rule we rely on our previous assumptions related to labor categories and number of hours as we did in the CY 2024 OPPS/ASC final rule (88 FR 82153). As we previously indicated, we estimate it will take a General and Operations manager 2 hours, per hospital, to review and determine updates in compliance with requirements. We estimate the ongoing time for a Business Operations Specialist to be 40 hours per hospital, to identify and gather the required data elements on an annual basis. We believe that it will take a Computer System Administrator 12 hours to maintain and post the MRF in a manner that conforms to the CMS standard template, which brings the total burden per hospital to 54 hours. Therefore, we estimate a total annual burden of 400,464 hours for all hospitals (7,416 hospitals × 54 hours) at a cost of $36,519,350.40 (7,416 hospitals × [($128/hour × 2 hours) + ($87.52/hour × 40 hours) + ($97.30/hour × 12 hours)]).

TABLE 4: SUMMARY OF ANNUAL BURDEN FOR THE INFORMATION COLLECTIONS IN THE 2026 OPPS/ASC PROPOSED RULE

Regulation section	OMB control no.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Total labor cost of reporting ($)
§ 180	0938-1369	7,416	7,416	54	400,464	$36,519,350.40

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

To generate salary estimates, for the table below, we used hourly wage data from the https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salarytables/pdf/2024/DCB_h.pdf published by the Office of Personnel Management (OPM) for the Washington-Baltimore-Arlington region. The table also estimates the average benefits, as a percentage of wages for federal employees, to be 80% according to a CBO study.[4] These estimates are based on our experience with monitoring hospitals for compliance with the requirements of the HPT

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

regulations over the past two years, and requiring additional compliance actions and imposing civil monetary penalties. Staffing estimates are based on CMS duties as follows:

- Investigative action if CMS receives a complaint. Clarify complaint, if necessary,
- Access, review and validate data posted on hospital website. Time estimate may vary depending on the validation procedures required.
- Notify hospital of noncompliance and need for corrective action: develop and send written warning notice and/or notice of violation requiring a corrective action plan (CAP); review and approve hospital's CAP; assist hospitals as needed to develop CAPs; monitor and evaluate hospital's compliance with the corrective action.
- Assessment of civil monetary penalties (CMPs), and posting of notice of assessment of CMPs on a CMS website and maintaining the website of these postings; responding to hospital appeals of CMPs and other legal issues.
- Provide policy guidance and technical assistance to stakeholders including hospitals, as needed.
- Provide publicly available information on best practices for hospitals to demonstrate procedures for maintaining compliance and highlight exemplars.
- This program takes 15 CMS staff at the following: one GS-9, one GS-12, eight GS-13, three GS-14, and two GS-15 for a total cost of $3,596,110, the breakdown of hours is presented below.

Estimate					
Staff	Hours	Wage	Benefits	Adjusted hourly wage	Total
GS-9, step 10	2,020	$42.61	$34.09	$76.70	$154,934.00
GS-12, step 1	2,020	$47.53	$38.02	$85.55	$172,811.00
GS-13, step 4	10,100	$62.17	$49.74	$111.91	$1,130,291.00
GS-13, step 9	4,040	$71.60	$57.28	$128.88	$520,675.20
GS-13, step 10	2,020	$73.48	$58.78	$132.26	$267,165.20
GS-14, step 2	2,020	$69.02	$55.22	$124.24	$250,964.80
GS-14, step 4	4,040	$73.47	$58.78	$132.25	$534,290.00
GS-15, step 4	2,020	$86.42	$69.14	$155.56	$314,231.20
GS-15, step 7	1,515	$91.9	$73.56	$165.51	$250,747.65

		5			
					$3,596,110.05

15. Changes to Burden

This is a reinstatement with change of a previously approved information collection. The annual burden has increased by 17,172 hours (from 383,292 hours to 400,464 hours). This is primarily due to an increase in the number of respondents required to post the required standard charge data and updated wage rates. We also note the additional one-time burden of 37,080 hours related to the implementation of the requirements in the 2026 CY OPPS/ASC proposed rule.

CMS is proposing hospitals include six additional data elements in the MRF: the median allowed amount; tenth percentile allowed amount; ninetieth percentile allowed amounts; count of allowed amounts; the name of the chief executive officer, president, or senior official designated to oversee the encoding of true, accurate and complete data in the MRF; and hospital NPI. We believe the benefits to users of the MRF having this additional information justify the initial one-time burden to hospitals to update their processes and systems to identify and collect the newly proposed data elements and encode the standard charge information for the newly proposed data elements in the CMS standard template.

16. Publication/Tabulation Dates

The results of this information collection will not be published.

17. Expiration Date

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

18. Certification Statement

There are no exceptions to the certification statement.