Supporting Statement – Part A

Collection of Information for the Hospital Outpatient Quality Reporting Program: CY 2027 OPPS/ASC Proposed Rule
(OMB# 0938-1109; CMS-10250)

A. Background

This is a revision of the currently approved information collection request. The Centers for Medicare & Medicaid Services' (CMS's) quality reporting programs promote higher quality, more efficient healthcare for consumers, including Medicare beneficiaries, by collecting and publicly reporting on quality-of-care metrics. This information informs consumer decision-making and incentivizes healthcare facilities to make continued improvements.

CMS has implemented quality reporting programs for multiple settings, including for hospital outpatient departments (HOPDs), as authorized by statute, and seeks to achieve an overarching priority to promote improvement, innovation, and modernization of care quality. Specifically, to better address health care priorities, reduce burden, and increase efficiency, CMS implements quality program by: (1) using only high-value quality measures impacting key quality domains; (2) aligning measures across value-based programs and across partners, including CMS, federal, and private entities; (3) prioritizing outcome and patient-reported measures; and (4) transforming measures by being fully digital and incorporating all-payer data.

Information collection requirements through the calendar year (CY) 2031 payment determination are currently approved under OMB control number 0938-1109 (expiration date June 30, 2029). This request covers data collection requirements for the CY 2029 payment determination and subsequent years for the Hospital Outpatient Quality Reporting Program. This updated information collection request discusses changes in burden associated with the proposed removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure, proposed incorporation of validation for electronic clinical quality measures (eCQMs), proposed reduction of the validation selection pool from 500 to up to 400 HOPDs, and proposed modification to the number of chart-abstracted cases required for validation from 12 per quarter to a maximum of 8 per quarter per measure.

B. Justification

1. Need and Legal Basis

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

[1] Pub. L. 109-432

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

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include those 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 Hospital Inpatient Quality Reporting Program.

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

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

(a) Hospital Outpatient Quality Reporting Program Quality Measures

Hospital Outpatient Quality Reporting Program payment determinations are based on the reporting of data and submission of applicable forms by HOPDs on measures derived from multiple data sources, including, patient medical records; electronic health records (EHRs); health information technology (HIT) systems; Medicare fee-for-service (FFS) claims; beneficiary and enrollment data; web submission forms; patient surveys, and data validation for selected HOPDs. To reduce burden, CMS uses a variety of data collection mechanisms and prioritizes data sources and data collection systems that are already in place.

Measures for the Hospital Outpatient Quality Reporting Program data are submitted via one of several modes: (1) chart-abstracted; (2) claims and other administrative data; (3) digital; and (4) survey-based and other patient-reported data. See the list of currently approved program measures in Table 1.

Chart-abstracted measures rely on information manually abstracted from patient medical records. Because chart abstraction requires manual data entry, these measures typically impose higher burden on HOPDs than other types of measures.

Claims and other administrative data use information are derived from Medicare Fee-for-Service (FFS) claims, Medicare Advantage encounter data, and beneficiary enrollment data. Because these data are submitted by HOPDs to CMS for payment purposes, claims-based measures do not impose additional burden from HOPDs.

Digital measures include eCQMs and web-based measures. For eCQMs, information is electronically extracted from EHRs and/or HIT systems. For "web-based" measures, HOPDs are required to submit measure data via CMS' Hospital Quality Reporting (HQR) system.

The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey relies on patient responses and requires HOPDs to have the survey administered by a third-party vendor and have he survey data submitted to CMS under OMB control number 0938-1240 (expiration November 30, 2026). The Hospital-Level Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Patient-Reported Outcomes-Based Performance Measure (PRO-PM) uses four sources of data for the calculation of the measure: (1) PRO data; (2) Medicare claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. HOPDs collect the PRO data and responses are submitted electronically through the CMS HQR system; Medicare claims data, enrollment and beneficiary data, and U.S. Census Bureau survey data are collected via other mechanisms and do not impose additional burden on HOPDs.

Table 1. Previously Finalized Hospital Outpatient Quality Reporting Program Measures for the CY 2028 Payment Determination and Subsequent Years

Measure Data Submission Mode and Name
Chart-Abstracted Measures
Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients*
Head Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
Claims-Based Measures
MRI Lumbar Spine for Low Back Pain
Abdomen CT – Use of Contrast Material
Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy
Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery
Breast Cancer Screening Recall Rates
Web-Based Measures
Left Without Being Seen*
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients**

Measure Data Submission Mode and Name
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
Electronic Clinical Quality Measures (eCQMs)
ST-Segment Elevation Myocardial Infarction (STEMI) eCQM
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Hospital Level – Outpatient) eCQM (Excessive Radiation eCQM)
Emergency Care Access & Timeliness eCQM***
Patient-Reported Outcomes-Based Performance Measures (PRO-PMs)
Risk-Standardized PRO–PM Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty in the HOPD Setting (THA/TKA PRO-PM)
Survey-Based Measures
Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)

*These measures were finalized for removal beginning with the CY 2030 payment determination in the CY 2026 OPPS/ASC final rule.
**This measure is proposed for removal beginning with the CY 2029 payment determination in the CY 2027 OPPS/ASC proposed rule.
***This measure was finalized for adoption beginning with the CY 2029 payment determination in the CY 2026 OPPS/ASC final rule.

(b) Summary of Proposed Hospital Outpatient Quality Reporting Program Changes

In the CY 2027 OPPS/ASC proposed rule, we proposed to: (1) remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination; (2) incorporate validation of eCQMs into the existing validation process for chart-abstracted measures beginning with eCQM data from the CY 2027 reporting period affecting the CY 2030 payment determination; (3) reduce the validation selection pool from 500 to up to 400 HOPDs beginning with validation affecting the CY 2030 payment determination; and (4) remove the requirement for hospitals to resubmit medical documentation as part of their request for reconsideration of validation noncompliance, beginning with data from the CY 2026 reporting period affecting the CY 2028 payment determination.

As part of our proposal to incorporate validation of eCQMs into the existing validation process , we proposed to: (1) modify the number of chart-abstracted cases required for validation from 12 per quarter to a maximum of 8 per quarter per measure beginning with validation affecting the CY 2030 payment determination; (2) replace the previously finalized 2-year validation cycle with a 3-year validation cycle, where hospitals selected for validation based on CY 2027 data affecting the CY 2029 payment determination would not be selected again for validation of the same data affecting the CY 2030 payment determination; (3) determine eCQM validation scores using the same methodology currently used to score chart-abstracted measure validation; (4) revise the policy to allow the results of educational reviews for all four quarters of chart-abstracted measure validation to be reflected in the final validation score prior to the calculation of the confidence interval; and (5) extend the educational review process established for chart-abstracted measure validation to eCQM validation. With the exception of updating the number of

chart-abstracted cases required for validation discussed in section 12.i., these additional proposals would not impact information collection burden as they neither change the amount of data submitted or frequency of data submission required for HOPDs.

(c) Hospital Outpatient Quality Reporting Program Administrative Forms

CMS has implemented procedural requirements that align the hospital and ASC quality reporting programs, which involve submission of certain forms to comply with program requirements or for specified program functions. As a result, many of the forms are used for multiple programs and are included under OMB control numbers 0938-1022 and 0938-1240 to reduce administrative burden and the potential for errors when updates are necessary.

The Hospital Outpatient Quality Reporting Program uses six administrative forms: (1) Extraordinary Circumstances Exception (ECE) Request; (2) Reconsideration Request; (3) Validation Review; (4) Withdrawal of Participation Form; (5) Request Form for Withholding/Footnoting Data From Public Reporting; and (6) Participation Exemption Request (PER) Form for OAS CAHPS. None of these forms are completed on an annual basis; all are on a need-to-use, exception basis and most HOPDs will not need to complete any of these forms in any given year. Thus, the burden for providers associated with forms utilized in the Hospital Outpatient Quality Reporting Program is nominal, if any.

(1) ECE Request Form

CMS offers a process for HOPDs to request an exception or extensions to the reporting of required quality data, for one or more quarters when an HOPD experiences an extraordinary circumstance beyond the HOPD's control, such as a cyberattack or natural disaster. The CMS Quality Program ECE Request Form indicates that for non-eCQMs, the request must be submitted within 60 calendar days of an extraordinary circumstance event for all programs. In addition, the form indicates that for eCQM reporting under the Hospital Outpatient Quality Reporting Program, the request must be submitted by June 15 following the end of a reporting period calendar year.

(2) Reconsideration Request Form

If CMS determines that an HOPD did not met program requirements and is subject to a 2.0 percentage point reduction in their APU, HOPDs may submit a Reconsideration Request to CMS no later than the first business day[2] 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.

[2] 42 CFR § 416.310(f) All deadlines occurring on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order are extended to the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order.

(3) Validation Review Form

CMS performs a random and targeted selection of HOPDs reporting under the Hospital Outpatient Quality Reporting Program on an annual basis. The selection includes up to 500 HOPDs — up to 450 randomly selected HOPDs and up to 50 targeted HOPDs. In the event that CMS determines an HOPD did not meet the Hospital Outpatient Quality Reporting Program validation requirement due to a confidence interval validation score of less than 75 percent, the HOPD may complete and submit the Validation Review Form online. In the CY 2027 OPPS/ASC proposed rule, we are proposing to reduce the validation selection pool from 500 to up to 400 HOPDs (up to 200 randomly selected and up to 200 targeted HOPDs) beginning with validation affecting the CY 2030 payment determination.

(4) Withdrawal of Participation Form

Once an HOPD submits quality measure data (e.g., using the web-based data collection tool), and the submission is accepted, the HOPD will be considered a participant of the Hospital Outpatient Quality Reporting Program, regardless of whether it continues to submit quality measure data, until it formally withdraws. To withdraw from the Hospital Outpatient Quality Reporting Program after submitting quality measure data, an HOPD must complete and submit a Withdrawal of Participation Form by August 31st for the applicable CY.

(5) Request Form for Withholding/Footnoting Data from Public Reporting

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

(6) PER Form for OAS CAHPS

HOPDs may use the PER form to request an exemption from conducting the OAS CAHPS survey for one year; HOPDs must request an exemption annually. HOPDs that meet OAS CAHPS eligibility and served fewer than 60 OAS CAHPS survey-eligible patients between January 1 and December 31 of the prior CY can request an exemption for the current year (for example, HOPDs that served fewer than 60 survey-eligible patients in CY 2025 can request a exemption for the OAS CAHPS survey data collection period occurring in CY 2026). On an annual basis, CMS reviews all participation exemption requests and decides whether to approve or deny. The information collection burden for this form is accounted for under OMB control number 0938-1240.

HOPDs statutorily required to participate in the Hospital Outpatient Quality Reporting Program may submit a request to add a footnote to claims-based measure data publicly reported on the Compare Tool or its successor website. If the request is approved, the footnote would be added to the data, indicating the facility has identified errors in their claims-based measure data during

the program-specific preview period for the applicable reporting period. Hospitals may request to footnote any or all claims-based measures. Forms must be received before the end of the preview period in order to be considered.

2. Information Users

The Hospital Outpatient Quality Reporting Program, as a pay-for-reporting program, strives to have a streamlined measure set that serves to meaningfully differentiate facilities by quality of care while limiting burden to the fullest extent possible. CMS provides confidential feedback reports that HOPDs may use to assess their performance and implement quality improvement activities. These reports include data that CMS has collected from the HOPD with information about how the HOPD's data compare to the performance of other HOPDs. For example, the Facility, State and National Report allows hospitals to compare their performance on a specific measure during a specific timeframe to the average performance of other HOPDs at the state and national levels. Additionally, Quality Improvement Organizations (QIOs) use Hospital Outpatient Quality Reporting Program data to improve quality of care through education, outreach, and sharing best practices.

This information is made publicly available; Medicare beneficiaries, as well as the general public, through the Compare tool, which helps the public make informed decisions about their care. CMS periodically conducts focus groups or market testing to get feedback on ways to make the website more user-friendly. Feedback from these focus groups has helped CMS understand how beneficiaries and consumers use the Compare tool. Under emergency circumstances, consumers choose hospitals based on proximity, reputation, prior experience, or their doctor's recommendation. For elective hospital admissions, when patients and their family members may have the time and motivation to consider options and engage in informed decision making, they have expressed interest the provider's track record in treating their condition, safety and infection rates, and a hospital's recognized areas of expertise, as well as their doctor's recommendation.

Under section 1890A(a)(6) of the Social Security Act, CMS is required to evaluate the impact and efficiency of CMS measures in quality reporting programs and to post the report every three years. Following the compilation of data from the Hospital Outpatient Quality Reporting Program and other CMS quality programs, CMS's findings were formally written into the latest triennial National Impact Assessment Report released in 2024.[3]

3. Use of Information Technology

To assist HOPDs in participating in standardized data collection initiatives across the industry, CMS continues to improve data collection tools with the dual goals of making data submission easier (for example, the automated collection of electronic patient data in EHRs for eCQMs, and the free CMS Abstraction and Reporting Tool for use in collecting data from paper or electronic medical records for chart-abstracted measures), and to increase the utility of the data provided by the HOPDs. CMS also provides a secure data warehouse via the HQR system for storage and

[3] 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.

transmittal of data as well as data validation and aggregation services prior to the release of data to the CMS website. HOPDs have the option of using authorized vendors to transmit data, with the exception of OAS CAHPS, for which using an authorized vendor to transmit data is required. CMS has engaged a national support contractor to provide technical assistance with the data collection tool and other program requirements, and to provide education to support program participants.

As reflected by the collection and reporting of claims-based quality measures, quality measures submitted via the HQR system, and measures which are derived digitally, 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 the type of data collected and data collection mechanism in Table 1.

For the claims-based measures or measures which use data from claims, Medicare Advantage encounter data, and other administrative data in part, this section is not applicable, because these measures can be fully or partially calculated based on data that are already reported to the Medicare program for payment purposes. Therefore, no additional information technology will be required of hospitals to collect these data for these measures.

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect quality of care data for hospital outpatient care. CMS requires HOPDs to submit quality measure data for services provided in the outpatient setting. We prioritize efforts to reduce reporting burden for the collection of quality-of-care information by utilizing electronic data that HOPDs already collect.

5. Small Business

Information collection requirements are designed to allow maximum flexibility, specifically to small HOPDs participating in the Hospital Outpatient Quality Reporting Program. We define a "small HOPD" as one with 1-99 beds. For the CY 2027 payment determination, 850 program-eligible, 74 Critical Access, and 37 voluntarily reporting small HOPDs participated in the Hospital Outpatient Quality Reporting Program.

The Health Resources and Services Administration (HRSA)'s Medicare Rural Hospital Flexibility Program and Medicare Beneficiary Quality Improvement Project, as well as CMS' QIOs, provide technical assistance to small and rural hospitals to reduce burden and improve healthcare quality. CMS also provides a help-desk hotline for troubleshooting and 24/7 free information available on the QualityNet website through a Questions and Answers function. These activities will assist small HOPDs in gathering information for their own quality improvement efforts and for meeting Hospital Outpatient Quality Reporting Program information collection requirements.

6. Less Frequent Collection

CMS has designed the collection of quality-of-care data to be the minimum necessary for data validation and calculation of summary figures to be reliable estimates of HOPD performance. Frequency of data collection may vary (quarterly, annually, etc.) based on how a quality measure is specified. The following table (Table 2) details the frequency of data submission to CMS by measure type for the Hospital Outpatient Quality Reporting Program.

Table 2. Frequency of Data Submission Under the Hospital Outpatient Quality Reporting Program by Measure Type

Measure Type	Frequency of Data Submission
Chart-abstracted	Quarterly
Web-based	Annually, Quarterly
Survey-based	Quarterly
eCQM	Annually
PRO-PM	Annually

Claims-based measures use information derived from Medicare FFS claims data and MA encounter data; HOPDs submit claims for reimbursement or payment per claims processing timeliness requirements. To collect these measure data less frequently would compromise the timeliness of any calculated estimates.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

A 60-day Federal Register notice of the CY 2027 OPPS/ASC proposed rule (RIN 0938-AV83, CMS-1850-P) was published on July 7, 2026 (91 FR 41734).

Measures adopted for the Hospital Outpatient Quality Reporting Program are required by statute to undergo a recognized consensus process. Section 1890A of the Social Security 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 list as part of the Pre-Rulemaking Measure Review (PRMR). We refer readers to https://p4qm.org/PRMR/About for more information on the PRMR process.

9. Payments/Gifts to Respondent

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

10. Confidentiality

We pledge privacy to the extent provided by law. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted. All information collected under the Hospital Outpatient Quality Reporting 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 CFR. 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 HOPD-specific data will be made publicly available as mandated by statute.

Data related to the Hospital Outpatient Quality Reporting Program is housed in the HQR application group. CMS' HQR is a General Support System housing protected health information. 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 in use for quality programs, including the Hospital Outpatient Quality Reporting Program, is MBD 09-70-0536, as modified on February 14, 2018 (83 FR 6591).

11. Sensitive Questions

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

12. Burden Estimate (Total Hours & Wages)

(a) Background

In the CY 2027 OPPS/ASC proposed rule, we proposed to: (1) remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination; (2) incorporate validation of eCQMs into the existing validation process; (3) reduce the validation selection pool from 500 to up to 400 HOPDs; and (4) reduce the number of chart-abstracted cases required for validation from 12 per quarter to a maximum of 8 per quarter per measure.

We discuss other program updates proposed in the CY 2027 OPPS/ASC proposed rule which would not affect information collection burden under OMB control number 0938-1109 in section B.1.a.

(b) Burden for the CY 2028 Payment Determination

Our currently approved burden estimates assumed that approximately 3,200 HOPDs will report data to the Hospital Outpatient Quality Reporting Program. Based on the most recent available data from the CY 2026 Hospital Outpatient Quality Reporting Program payment determination, we estimate that 3,000 HOPDs will report data to the Hospital Outpatient Quality Reporting Program for the CY 2027 reporting period/CY 2029 payment determination and future years. For purposes of burden estimation, we assume all activities associated with the Hospital Outpatient Quality Reporting Program will be completed by Medical Records Specialists, apart from survey completion which will be completed by patients. These staff are qualified to complete the tasks associated with the chart abstraction of patient data from medical records, the submission of electronic data from EHRs, the submission of data to clinical registries, and the completion of any of the other applicable forms associated with activities related to the Hospital Outpatient Quality Reporting Program.

OMB has currently approved 3,226,046 hours under OMB control number 0938-1109, accounting for information collection burden experienced by approximately 3,200 HOPDs for the CY 2027 payment determination. As shown in Table 3, using updated wage rates and estimates for the number of reporting HOPDs, we estimate a revised baseline burden of 3,210,613 hours at a cost of $92,545,641 for the CY 2028 payment determination. As previously stated, our burden estimates exclude burden associated with 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 HOPDs. 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 Hospital Outpatient Quality Reporting Program Measure Set and Other Activities for the CY 2028 Payment Determination

Measure Set	***Estimated time per record (minutes) - CY 2028 payment determination***	***Number reporting quarters per year - CY 2028 payment determination***	***Number of respondents***	***Average number records per HOPD per quarter***	***Annual burden (hours) per HOPD***	***Total Burden Hours for CY 2028 payment determination***
Administrative Activities	2,520	1	3,000	1	42	**126,000**
Chart-Abstracted						

Measures						
Median Time from ED Arrival to ED Departure for Discharged ED Patients	2.92	1	3,000	289	14.2	42,600
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of Emergency Department Arrival	2.92	1	3,000	289	14.2	42,600
Chart-Abstracted Measure Subtotal						**85,200**
Web-Based Measures						
Left Without Being Seen	10	1	3,000	1	0.167	500
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	3,000	1	0.167	500
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Chart Abstraction)	2.92	1	3,000	96	4.7	14,112
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Reporting)	10	1	600	1	0.167	100
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Chart Abstraction)	2.92	1	600	96	4.7	2,822
Web-Based Measures Subtotal						**18,034**
eCQM Measures						
STEMI eCQM	10	3	3,000	1	0.33	1,500
Excessive Radiation eCQM (Voluntary)	10	1	600	1	0.167	100
Login and Run Software for Excessive Radiation eCQM (Voluntary)	15	1	600	1	0.25	150
Emergency Care Access & Timeliness eCQM*	0	0	0	0	0	0
eCQM Measures Subtotal						**1,750**
PRO-PM						
THA/TKA (Voluntary Patient Surveys)	7.25	2	131,698	1	0.12083	15,914
THA/TKA (Voluntary Reporting)	10	1	1,500	1	0.167	250
Information Transfer (Voluntary Patient Surveys)	5	1	35,486,575	1	0.083	2,957,215

Information Transfer (Voluntary Reporting)	10	1	1,500	1	0.167	250
PRO-PM Subtotal						**2,973,629**
Validation	15	1	500	48	12	**6,000**
Total Burden Hours						**3,210,613**
Total Burden @ Average Individual Labor rate ($26.56/hr)						**$78,966,306**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$13,579,335**

* Voluntary reporting for this eCQM begins with the CY 2029 payment determination.

Changes to currently approved burden estimates due to proposed measure adoptions and updated validation requirements in the CY 2027 OPPS/ASC proposed rule are discussed below.

(a) Updated Hourly Wage Rate

The most recent data from the Bureau of Labor Statistics May 2025 National Occupational Employment and Wage Estimates reflects a median hourly wage of $28.59 per hour for medical records specialists working in "general medical and surgical hospitals"[4] 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 to estimate the total cost is a reasonably accurate estimation method and allows for a conservative estimate of hourly costs. Accordingly, unless otherwise specified, we will calculate cost burden to hospitals using a wage plus benefits estimate of $57.18 per hour throughout the discussion in this section of this rule for the Hospital Outpatient Quality Reporting Program.

(b) Administrative Burden

Administrative burden involves the time and effort associated with maintaining familiarity with Hospital Outpatient Quality Reporting Program requirements (for example, participating in monthly educational webinars, reading measure specifications and program information, checking feedback reports to indicate a facility's current status or performance, reaching out to the Hospital Outpatient Quality Reporting Program support contractor to make specific inquiries); staying up to date with system requirements (for example, updating passwords, etc.); and communicating how program requirements must be operationalized within the individual facility.

As previously noted in Section B.1.c, the Hospital Outpatient Quality Reporting Program utilizes six forms in its administrative activities: (1) ECE Request; (2) Reconsideration Request; (3) Validation Review; and (4) Withdrawal from Participation Form; (5) Request Form for Withholding/Footnoting Data From Public Reporting; and (6) PER Form for OAS CAHPS. None of these forms are completed on an annual basis; all are on a need-to-use, exception basis and most HOPDs will not need to complete any of these forms in any given year. Thus, the

[4] U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed May 18, 2026. Available at: https://data.bls.gov/oes/#/industry/622100/2025.

burden associated with forms utilized in the Hospital Outpatient Quality Reporting Program is nominal, if any.

The burden associated with submitting an ECE Request is accounted for in OMB control number 0938-1022 (expiration date December 31, 2028) and is therefore excluded from this burden estimate. Additionally, consistent with regulations under the Paperwork Reduction Act of 1995, 5 CFR § 1320.4, the burden associated with filing a Reconsideration Request, Validation Review, or a Withdrawal from Participation Form is excluded from this package because this collection occurs during the conduct of an administrative action. As a result, the proposal to remove the requirement for hospitals to resubmit medical documentation as part of their request for reconsideration of validation noncompliance beginning with data from the CY 2026 reporting period affecting the CY 2028 payment determination does not affect information collection burden.

In the CY 2027 OPPS/ASC proposed rule, we did not propose any changes to the administrative burden for the CY 2027 payment determination. Thus, our estimates for administrative burden remain the same as those previously approved under this OMB control number. Specifically, we previously estimated, in the CY 2014 OPPS/ASC final rule with comment period (78 FR 75171), that the burden associated with completing administrative requirements is 42 hours per HOPD. Therefore, for all program-eligible HOPDs, we estimate a total annual administrative burden of 126,000 hours (42 hours per HOPD x 3,000 HOPDs) at a cost of $7,204,680 (126,000 hours x $57.18 per hour).

(c) Chart Abstraction Burden

For the CY 2027 reporting period/CY 2029 payment determination, the chart-abstracted measure set for the Hospital Outpatient Quality Reporting Program is comprised of the Median Time for Discharged ED Patients and the Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival measures. In the CY 2026 OPPS/ASC final rule, we removed the Median Time for Discharged ED Patients measure beginning with the CY 2028 reporting period/CY 2030 payment determination, when reporting for the Emergency Care Access & Timeliness eCQM becomes mandatory (see Section 12.g for discussion of the burden associated with this eCQM).

For chart-abstracted measures where patient-level data are submitted directly to CMS, we previously estimated in the CY 2016 OPPS/ASC final rule that it requires 2.92 minutes, or 0.049 hours per case per measure to collect and submit the data for each submitted case (80 FR 70582). Additionally, we estimate that an average of 289 cases is reported per HOPD for chart-abstracted measures. We therefore estimate that it will require approximately 14.2 hours (0.049 hours × 289 cases) at a cost of approximately $812 per HOPD (14.2 hours × $57.18) to collect and report data for each chart-abstracted measure. Therefore, for all participating HOPDs, we estimate an annual chart abstraction burden of 42,600 hours (14.2 hours per HOPD x 3,000 HOPDs) at a cost of $2,435,868 per measure (42,600 hours × $57.18). For the CY 2029 payment determination, the total annual burden for all HOPDs to submit both measures is estimated to be 85,200 hours (42,600 hours/measure × 2 measures) at a cost $4,871,736 (85,200 hours x $57.18). For the CY

2030 payment determination and subsequent years, the total annual burden for all HOPDs to submit the Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival measure is estimated to be 42,600 hours at a cost of $2,435,868.

Table 4. Estimated Burden for the Chart-Abstracted Measure Reporting and Submission Requirements for the CY 2029 through CY 2030 Payment Determination Years

Chart-Abstracted 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 2029 Payment Determination						
Median Time from ED Arrival to ED Departure for Discharged ED Patients measure	2.92	1	3,000	289	14.2	42,600
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival measure	2.92	1	3,000	289	14.2	42,600
Total Burden Hours						**85,200**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$4,871,736**
CY 2030 Payment Determination and subsequent years						
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival measure	2.92	1	3,000	289	14.2	42,600
Total Burden Hours						**42,600**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$2,435,868**

(d) Web-Based Measures Burden

There are three currently approved web-based measures in the Hospital Outpatient Quality Reporting Program for the CY 2027 reporting period/CY 2029 payment determination and subsequent years: (1) Left Without Being Seen (LWBS), (2) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients, and (3) Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. The Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure is voluntary; we estimate that approximately 20 percent of HOPDs will report on this measure. In the CY 2026 OPPS/ASC final rule, we removed the LWBS measure beginning with the CY 2028 reporting period/CY 2030 payment determination when reporting for the Emergency Care Access & Timeliness eCQM becomes mandatory (see Section 12.g for discussion of the burden associated with this eCQM). In the CY 2027 OPPS/ASC proposed rule, we proposed to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination.

We previously estimated in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70582), that HOPDs spend approximately 10 minutes, or 0.167 hours, per measure to report web-based measures. For the CY 2029 payment determination, we estimate a total annual burden for all HOPDs of 600 hours [(0.167 hours/HOPD x 3,000 HOPDs) + (0.167 hours/hospital × 3,000 hospitals × 20 percent)] at a cost of $34,308 (600 hours × $57.18) for two measures. For the CY 2030 payment determination and subsequent years, we estimate a total annual burden for all HOPDs of 100 hours (0.167 hours/hospital × 3,000 hospitals x 20 percent) at a cost of $5,718 (100 hours × $57.18).

There are two currently approved web-based measures in the Hospital Outpatient Quality Reporting Program measure set that also require chart abstraction: (1) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients, and (2) Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. We previously estimated that chart abstraction for a web-based measure requires 2.92 minutes, or 0.049 hours, per case per measure as finalized in the CY 2016 OPPS/ASC final rule (80 FR 70582). Based on the current Hospital Outpatient Quality Reporting Program Specifications Manual, the sample size requirement for HOPDs with populations of 900 patients or less is 63 cases annually and the requirements for HOPDs with populations of greater than 900 patients is 96 cases annually.[5] To be conservative, we base our burden estimates on an estimate of 96 cases per HOPD annually. Accounting for the proposed removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure, for the CY 2029 payment determination and subsequent years, we estimate a chart abstraction burden of 2,822 hours (0.049 hours/case × 96 cases/measure × 3,000 HOPDs x 20 percent) at a cost of $161,362 (2,822 hours × $57.18).

Table 5. Estimated Burden for the Web-Based Measure Reporting and Submission Requirements for the CY 2029 through CY 2030 Payment Determination Years

Web-Based Measure Reporting	***Estimated time per***	***Number reporting***	***Number of Responden***	***Average number***	***Annual burden***	***Total Annual***

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

	record (minutes)	*quarters per year*	*ts*	*records per Respondent per quarter*	*(hours) per Respondent*	*hours for all Respondents*
CY 2029 Payment Determination						
Left Without Being Seen	10	1	3,000	1	0.167	500
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Reporting)	10	1	600	1	0.167	100
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Chart Abstraction)	2.92	1	600	96	4.7	2,822
Total Burden Hours						**3,422**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$195,670**
CY 2030 Payment Determination and subsequent years						
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Reporting)	10	1	600	1	0.167	100
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Chart Abstraction)	2.92	1	600	96	4.7	2,822
Total Burden Hours						**2,922**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$167,080**

(e) Claims-Based Measures Burden

Claims-based measures are derived through analysis of administrative claims data and do not require additional effort or burden on HOPDs. As a result, the Hospital Outpatient Quality

Reporting Program's claims-based measures (see Table 1) do not influence our burden calculations.

(f) Survey Measures 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 0938-1109.

(g) eCQM Measures Burden

There are three eCQMs in the Hospital Outpatient Quality Reporting Program for the CY 2027 reporting period/CY 2029 payment determination and subsequent years: the Appropriate Treatment for ST-Segment Elevation Myocardial Infarction Patients in the Emergency Department (STEMI eCQM), the Excessive Radiation eCQM, and the Emergency Care Access & Timeliness eCQM.

HOPDs are required to report the STEMI eCQM for four quarters beginning with the CY 2027 reporting period/CY 2029 payment determination. Based on experience with reporting of eCQMs in the Hospital IQR Program, we estimate the time required for a Medical Records Specialist to submit the data required for the measure to be 10 minutes (0.167 hours) per quarter for each HOPD. For the CY 2027 reporting period/CY 2029 payment determination and subsequent years, we estimate the annual burden for all HOPDs to be 2,000 hours (3,000 HOPDs x 0.167 hours x 4 quarters) at a cost of $114,360 (2,000 hours x $57.18).

HOPDs may voluntarily report the Excessive Radiation eCQM. We estimate 20 percent of HOPDs will voluntarily report the measure for one or more quarters during each reporting period. Similar to the STEMI eCQM, we assume a Medical Records Specialist will require 10 minutes to submit the data required per quarter for each HOPD. For the CY 2027 reporting period and subsequent years, we estimate an annual burden for voluntarily participating HOPDs of 100 hours (3,000 HOPDs × 20 percent × 0.167 hours × 1 quarter) at a cost of $5,718 (100 hours × $57.18).

For the Excessive Radiation eCQM, HOPDs will log in through the measure developer's secure portal and run the free Alara Imaging Software for CMS Measure Compliance (or similar software) inside their firewall. The software runs automatically to create the three intermediate data elements needed for the measure. Once the software finishes creating these intermediate variables, HOPDs can send the data to its EHR for measure calculation and reporting. The software allows additional options such as the ability to send the data to other business associates of the HOPD if needed. No manual data entry is required. We continue to estimate that each voluntarily participating HOPD will spend approximately 15 minutes (0.25 hours) annually to conduct these activities prior to data submission. We estimate an annual burden of 150 hours (0.25 hours x 3,000 HOPDs × 20 percent) at a cost of $8,577 (150 hours × $57.18).

In the CY 2026 OPPS/ASC final rule, we adopted the Emergency Care Access & Timeliness eCQM beginning with voluntary reporting for the CY 2027 reporting period, followed by mandatory reporting beginning with the CY 2028 reporting period/CY 2030 payment determination. Similar to the information collection burden for the other eCQMs under the Hospital Outpatient Quality Reporting Program, we assume a Medical Records Specialist will require 10 minutes (0.167 hours) to submit the data required per quarter for each HOPD or 40 minutes (0.67 hours; 10 minutes × 4 quarters) annually. For voluntary reporting for the CY 2027 reporting period, HOPDs will be able to voluntarily submit at least one quarter and up to four quarters of data. For voluntary reporting for the CY 2027 reporting period, in which we estimate 20 percent of HOPDs will voluntarily report one quarter of data, we estimate an annual burden for HOPDs of 100 hours (3,000 HOPDs × 20 percent × 0.167 hours × 1 quarter) at a cost of $5,718 (100 hours × $57.18). Beginning with the CY 2028 reporting period/CY 2030 payment determination, we estimate the annual burden for all participating HOPDs to be 2,000 hours (0.67 hours x 3,000 HOPDs) at a cost of $114,360 (2,000 hours x $57.18).

Based on the calculations discussed in this section, we estimate a total burden for reporting eCQMs for the CY 2027 reporting period/CY 2029 payment determination of 2,350 hours (2,000 + 100 + 150 + 100) at a cost of $134,373 ($114,360 + $5,718 + $8,577 + $5,718). For the CY 2028 reporting period/CY 2030 payment determination and subsequent years, we estimate a total annual burden of 4,250 hours (2,000 + 100 + 150 + 2,000) at a cost of $243,015 ($114,360 + $5,718 + $8,577 + $114,360).

Table 6. Estimated Burden for the eCQM Reporting and Submission Requirements for the CY 2029 through CY 2030 Payment Determination Years

eCQM Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of HOPDs reporting***	***Average number records per HOPD per quarter***	***Annual burden (hours) per HOPD***	***Total Annual hours for all HOPDs***
CY 2029 Payment Determination						
STEMI eCQM	10	4	3,000	1	0.67	2,000
Excessive Radiation eCQM (Voluntary)	10	1	600	1	0.167	100
Login and Run Software for Excessive Radiation eCQM (Voluntary)	15	1	600	1	0.25	150
Emergency Care Access &Timeliness eCQM (Voluntary)	10	1	600	1	0.167	100
Total Burden Hours						**2,350**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$134,373**
CY 2030 Payment Determination and Subsequent Years						
STEMI eCQM	10	4	3,000	1	0.67	2,000

Excessive Radiation eCQM (Voluntary)	10	1	600	1	0.167	100
Login and Run Software for Excessive Radiation eCQM (Voluntary)	15	1	600	1	0.25	150
Emergency Care Access & Timeliness eCQM (Mandatory)	10	4	3,000	1	0.67	2,000
Total Burden Hours						**4,250**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$243,015**

(h) Patient-Reported Outcome Measures

In the CY 2024 OPPS/ASC final rule, we adopted the Hospital-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (THA/TKA PRO-PM) with voluntary reporting beginning with the CY 2025 reporting period through the CY 2027 reporting period, followed by mandatory reporting beginning with the CY 2028 reporting period/CY 2031 payment determination. This measure was previously adopted for the Hospital IQR Program in the FY 2023 IPPS/LTCH PPS final rule with an estimated burden of 7.25 minutes (0.120833 hours) per patient to complete both the pre-operative and post-operative surveys and 10 minutes (0.167 hours) per hospital per response to collect and submit the measure data via the HQR system (87 FR 49386 through 49387). We use the same burden estimates for both patient surveys and data submission for the Hospital Outpatient Quality Reporting Program.

The 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 claims data, Medicare enrollment and beneficiary data, and U.S. Census Bureau survey data as these data are already collected via other mechanisms such as Medicare enrollment forms, CMS Form 1500, and U.S. Census Informational Questionnaires. Many HOPDs have already incorporated PRO data collection into their workflows. While we did not specify how HOPDs collect PRO data for this measure, HOPDs new to collecting PRO data will have multiple options for when and how they will collect these 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 HOPD. The modes of PRO data collection can include completion of the pre-operative surveys using electronic devices (such as an iPad or tablet), pen and paper, mail, telephone, or through a patient portal. Post-operative PRO data collection modes are similar to pre-operative modes. The possible patient touchpoints for post-operative data collection can occur before the follow-up appointment, at the doctor's office, or after the follow-up appointment. The potential modes of PRO data collection for post-operative data are the same as for pre-operative data. If the patient does not or cannot attend a follow-up appointment, the modes of collection can include completion of the post-operative survey using email, mail, telephone, or through a patient portal. Similar to other surveys, like the OAS CAHPS, we believe

the use of multiple modes will maximize response rates as it allows for different patient preferences.

For the THA/TKA PRO–PM data, HOPDs will be able to submit data during three voluntary periods. The first voluntary reporting period began in CY 2025 for eligible procedures occurring between January 1, 2025, through December 31, 2025; the second voluntary reporting period began with CY 2026 for eligible procedures occurring between January 1, 2026, through December 31, 2026; and the third voluntary reporting period will begin in 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 January 1, 2028, through December 31, 2028), impacting the CY 2031 payment determination. HOPDs will need to submit data twice (pre-operative data and post-operative data) for each reporting period.

For the purposes of calculating burden, similar to assumptions used for the Hospital IQR Program in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49386 through 49387), we estimate that during the voluntary periods, 50 percent of HOPDs that perform at least one THA/TKA procedure will submit data for 50 percent of THA/TKA patients. For purposes of calculating burden, we estimate that, during the mandatory period, 100 percent of HOPDs will submit for 100 percent of patients. While we finalized a requirement for HOPDs 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 HOPDs exceed this threshold.

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 $26.56/hr 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.[6] To derive the costs for patients (or their representatives), a measurement of the usual weekly earnings of wage and salary workers of $1,235 is divided by 40 hours to calculate an hourly pre-tax wage rate of $30.88/hr.[7] 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,[8] resulting in the post-tax hourly wage rate of $26.56/hr. Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs because the individuals' activities, if any, would occur outside the scope of their employment.

For burden estimating purposes for this measure, we assume that most HOPDs will likely undertake PRO data collection through a screening tool incorporated into their EHR or other

[6] 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.

[7] 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 May 20, 2026.

[8] U.S. Census Bureau, Income in the United States: 2024. September 2025. Available at https://www2.census.gov/library/publications/2025/demo/p60-286.pdf. Accessed May 20, 2026.

patient intake process. We estimate that approximately 526,793 THA/TKA procedures occur in the outpatient setting each year, and that many patients can 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 voluntary reporting for the CY 2027 reporting period, we assume 50 percent of patients from 50 percent of the hospitals, or 131,698 patients, will complete the survey (526,793 patients × 0.50 × 0.50 of hospitals) for a total of 15,914 hours annually (131,698 respondents × 0.120833 hours) at a cost of $422,676 (15,914 hours × $26.56). Beginning with mandatory reporting in the CY 2028 reporting period, we estimate a total of 63,654 hours (526,793 patients × 0.120833 hours) at a cost of $1,690,650 (63,654 hours × $26.56) across all HOPDs.

Regarding HOPDs' 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. HOPDs 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 which occurred in CY 2025, pre-operative survey data submission occurred 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 reporting period, we estimate that each HOPD will spend 20 minutes (0.33 hours) annually (10 minutes × 2 surveys) to collect and submit the data. For the CY 2027 and CY 2028 reporting periods, we estimate 50 percent of HOPDs will voluntarily participate, resulting in a burden of 500 hours (0.33 hours × 3,000 HOPDs × 50 percent) at a cost of $28,590 (500 hours × $57.18). For the CY 2029 reporting period in which HOPDs may voluntarily report the first half of the reporting period and mandatorily report the second half of the reporting period, we estimate a burden for all HOPDs of 750 hours [(0.167 hours × 3,000 HOPDs × 50 percent) + (0.167 hours × 3,000 HOPDs)] at a cost of $42,885 (750 hours × $57.18). For mandatory reporting for the CY 2030 reporting period and subsequent years, we estimate a total of 1,000 hours (0.33 hours × 3,000 HOPDs) at a cost of $57,180 (1,000 hours × $57.18).

In the CY 2025 OPPS/ASC final rule, we adopted the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery (Information Transfer) PRO-PM beginning with voluntary reporting for the CY 2026 reporting period and mandatory reporting beginning with the CY 2027 reporting period/CY 2029 payment determination. The Information Transfer PRO–PM uses PRO data regarding recovery instructions, collected by HOPDs through a nine-item survey instrument administered to patients post-operatively. The modes of PRO data collection can include completion of the post-operative surveys electronically.

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 American Hospital Association related to hospital outpatient visits to estimate that each year there are roughly 854,120,358 hospital outpatient visits ((2,499 outpatient visits per 1,000 population in

CY 2024[9]) × 341,784,857 total U.S population[10]). We then estimate a total of 499,660,409 HOPD patient visits potentially resulting in a patient needing to be screened when the measure becomes mandatory by multiplying the total 854,120,358 hospital outpatient visits by a ratio of 3,000 HOPDs to the total of 5,129 Community Hospitals in the U.S.[11] (854,120,358 hospital outpatient visits × 58.5 percent (3,000 HOPDs ÷ 5,129 hospitals surveyed)). However, as not all hospital outpatient visits are related to surgeries and procedures, and there are often multiple visits such as pre- and post-op visits associated with those that are, we estimate that 163,553,470 hospital outpatient visits (499,660,409 hospital outpatient visits ÷ 3 surgery or procedure-specific visits) would more realistically qualify for the cohort of this measure. While HOPDs may report a minimum random sample if they are able to collect at least 300 completed patient surveys or all surveys responses if an HOPD is unable to collect at least 300, we require all patients to be surveyed for this measure.

We estimate each patient will require an average of 5 minutes (0.083 hours) to complete the survey.[12] For the CY 2027 reporting period and subsequent years, we estimate an annual total burden for patients of 13,629,456 hours (163,553,470 patients × 0.083 hours per patient) at a cost of $361,998,351 (13,629,456 hours × $26.56).

Measure data will be submitted via the HQR system annually. Similar to the currently approved burden estimate for other web-based measures reported via the HQR system for the Hospital Outpatient Quality Reporting Program, we estimate a burden of 10 minutes (0.167 hours) per HOPD to report measure data. For the CY 2027 reporting period and subsequent years, we estimate a total collection and reporting burden for program-eligible HOPDs of 500 hours (3,000 HOPDs × 0.167 hours per HOPD) at a cost of $28,590 (500 hours × $57.18).

Table 7. Estimated Burden for the PRO-PM Reporting and Submission Requirements for the CY 2029 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***

[9] Kaiser Family Foundation, Hospital Outpatient Visits per 1,000 Population by Ownership Type. Available at https://www.kff.org/other/state-indicator/outpatient-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[10] United States Census Bureau – Quickfacts. Available at https://www.census.gov/quickfacts/fact/table/US. Accessed May 28, 2026.

[11] American Hospital Association – Fast Facts on U.S. Hospitals 2024. Available at https://www.aha.org/system/files/media/file/2024/01/fast-facts-on-us-hospitals-2024-20240112.pdf.

[12] Yale New Haven Health Services Corporation - Center for Outcomes Research & Evaluation, Methodology Report For Public Comment: Patient Understanding of Key Information Related to Recovery From an Outpatient Surgery or Procedure. Available at https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/measure-methodologyhttps://mmshub.cms.gov/sites/default/files/Patient-Receipt-Key-Info-Public-Comment-03082022.pdf.

CY 2029 Payment Determination						
THA/TKA (Voluntary Patient Surveys)	7.25	2	131,698	1	0.12083	15,914
THA/TKA (Voluntary Measure Reporting)	10	2	1,500	1	0.33	500
Information Transfer (Mandatory Patient Surveys)	5	1	163,553,470	1	0.083	13,629,456
Information Transfer (Mandatory Reporting)	10	1	3,000	1	0.167	500
Total Burden Hours						**13,646,370**
Total Burden @ Individual labor rate ($26.56/hr)						**$362,421,027**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$57,180**
CY 2030 Payment Determination						
THA/TKA (Mandatory Patient Surveys)	7.25	2	526,793	1	0.12083	63,654
THA/TKA (Voluntary Measure Reporting)	10	2	1,500	1	0.33	500
Information Transfer (Mandatory Patient Surveys)	5	1	163,553,470	1	0.083	13,629,456
Information Transfer (Mandatory Reporting)	10	1	3,000	1	0.167	500
Total Burden Hours						**13,694,110**
Total Burden @ Individual labor rate ($26.56/hr)						**$363,689,002**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$57,180**
CY 2031 Payment Determination						
THA/TKA (Mandatory Patient Surveys)	7.25	2	526,793	1	0.12083	63,654
THA/TKA (Voluntary Measure Reporting)	10	1	1,500	1	0.167	250
THA/TKA (Mandatory Measure Reporting)	10	1	3,000	1	0.167	500
Information Transfer (Mandatory Patient Surveys)	5	1	163,553,470	1	0.083	13,629,456
Information Transfer (Mandatory Reporting)	10	1	3,000	1	0.167	500
Total Burden Hours						**13,694,360**
Total Burden @ Individual labor rate ($26.56/hr)						**$363,689,002**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$71,475**

CY 2032 Payment Determination and Subsequent Years						
THA/TKA (Mandatory Patient Surveys)	7.25	2	526,793	1	0.12083	63,654
THA/TKA (Mandatory Measure Reporting)	10	2	3,000	1	0.33	1,000
Information Transfer (Mandatory Patient Surveys)	5	1	163,553,470	1	0.083	13,629,456
Information Transfer (Mandatory Reporting)	10	1	3,000	1	0.167	500
Total Burden Hours						**13,694,610**
Total Burden @ Individual labor rate ($26.56/hr)						**$363,689,002**
Total Burden @ Medical Records Specialist labor rate ($57.18/hr)						**$85,770**

(i) Validation Burden

The burden associated with the validation procedures is the time and effort necessary to submit supporting medical record documentation for validation. We previously estimated that it takes each of the 500 selected HOPDs approximately 15 minutes (0.25 hours) per case, or 12 hours in total (0.25 hours per case × 12 cases × 4 quarters) to comply with these data submission requirements (76 FR 74553 and 74577). To comply with the requirements, we also estimated that each HOPD will submit up to 48 cases for the affected year for review (76 FR 74553). In the CY 2027 OPPS/ASC proposed rule, we proposed to reduce the validation selection pool from 500 to up to 400 HOPDs beginning with validation affecting the CY 2030 payment determination and to modify the number of chart-abstracted cases required for validation from 12 per quarter to a maximum of 8 per quarter per measure. We note submission of medical documentation would occur in the CY immediately following the CY of the data being submitted (for example, CY 2027 data would be submitted in CY 2028 and CY 2028 data would be submitted in CY 2029).

In the CY 2027 OPPS/ASC proposed rule, we proposed to replace the previously finalized 2-year validation cycle with a 3-year validation cycle, where hospitals selected for validation based on CY 2027 data affecting the CY 2029 payment determination would not be selected again for validation of the same data affecting the CY 2030 payment determination. For the CY 2030 payment determination, CY 2027 chart-abstracted data would be used again in combination with CY 2027 eCQM data for validation. That is, validation results for CY 2027 chart-abstracted data would impact both the CY 2029 and CY 2030 payment determinations. Table 8 below illustrates the measures that are proposed for validation in future years.

Payment Determination Year	Reporting Period Data	Measures Included in Validation	Number of Measures Validated	Number of Cases Validated
CY 2029	CY 2027	1) Median Time from ED Arrival to ED Departure for Discharged ED Patients 2) Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45	2	48 cases under current policy

		minutes of ED Arrival		
CY 2030	CY 2027	1) Median Time from ED Arrival to ED Departure for Discharged ED Patients 2) Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival 3) STEMI eCQM	3	Up to 96 cases under proposals in CY 2027 OPPS/ASC proposed rule
CY 2031 (and subsequent years)	CY 2028 (and subsequent years)	1) Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival 2) STEMI eCQM 3) Emergency Care Access & Timeliness eCQM	3	Up to 96 cases under proposals in CY 2027 OPPS/ASC proposed rule

Regarding validation for chart-abstracted measures, because all selected HOPDs must comply with these requirements each year, for the CY 2029 payment determination, we estimate a total submission of up to 24,000 charts by the selected HOPDs (500 HOPDs × 12 cases per quarter per HOPD x 4 quarters) and a resulting total validation burden of 6,000 hours (500 HOPDs x 12 hours per HOPD) at a cost of $343,080 (6,000 hours x $57.18). For the CY 2030 payment determination, we estimate a total submission of up to 25,600 charts by the selected HOPDs (400 HOPDs × 8 cases per quarter per HOPD x 4 quarters x 2 measures) and a resulting total annual validation burden of 6,400 hours (400 HOPDs x 8 hours per HOPD x 2 measures) at a cost of $365,952 (6,400 hours x $57.18). For the CY 2031 payment determination and subsequent years, we estimate a total submission of up to 12,800 charts by the selected HOPDs (400 HOPDs × 8 cases per quarter per HOPD x 4 quarters x 1 measure) and a resulting total annual validation burden of 3,200 hours (400 HOPDs x 8 hours per HOPD x 1 measure) at a cost of $182,976 (3,200 hours x $57.18).

Regarding validation of eCQMs, in the CY 2027 OPPS/ASC proposed rule, we assume HOPDs would only need to upload one PDF file per case to CMS' HQR system and, therefore, estimate that it takes each of the 400 selected HOPDs approximately 1 minute (0.0167 hours) per case per eCQM, or 0.533 hours in total per eCQM (0.0167 hours per case x 8 cases x 4 quarters) to comply with these data submission requirements. Because all selected HOPDs must comply with these requirements each year, for the CY 2030 payment determination, we estimate a total submission of up to 12,800 charts by the selected HOPDs (400 HOPDs × 8 cases per quarter per HOPD x 4 quarters x 1 eCQM) and a resulting total annual validation burden of 213 hours (400 HOPDs x 0.533 hours per HOPD x 1 eCQM) at a cost of $12,198 (213 hours x $57.18). For the CY 2031 payment determination and subsequent years, we estimate a total submission of up to 25,600 charts by the selected HOPDs (400 HOPDs × 8 cases per quarter per HOPD x 4 quarters x 2 eCQMs) and a resulting total annual validation burden of 427 hours (400 HOPDs x 0.533 hours per HOPD x 2 eCQMs) at a cost of $24,397 (427 hours x $57.18).

(j) Total Burden for the CY 2029 through CY 2032 Payment Determinations

As shown in Tables 9 and 10, in summary, under OMB control number 0938-1109, we estimate a total annual information collection burden of 13,869,342 hours at a cost of $375,227,746 for the CY 2027 reporting period/CY 2029 payment determination. We also estimate a net annual increase of 1,770,821 hours and $46,121,215 for 3,000 HOPDs associated with our proposed measure removals, updates to validation requirements, and updated assumptions described above related to these information collections (which also reflects use of updated hourly wage rates as previously discussed), from the CY 2027 reporting period/CY 2029 payment determination through the CY 2030 reporting period/CY 2032 payment determination, compared to our currently approved information collection burden estimates. This net annual increase of 1,770,821 hours is comprised of a decrease of 29,677 associated with proposals in the CY 2027 OPPS/ASC proposed rule and a revised estimate of HOPDs offset by an increase of 1,800,498 hours due to an increase in the estimated number of patients surveyed for the Information Transfer PRO-PM. 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 2032 payment determination reflects the cumulative burden changes).

Table 9. Total Burden Hours for the CY 2029 through CY 2032 Payment Determinations

Information Collection	CY 2029	Difference from Currently Approved	CY 2030	Difference from Currently Approved	CY 2031	Difference from Currently Approved	CY 2032	Difference from Currently Approved
Administrative Activities	126,000	-8,400	126,000	-8,400	126,000	-8,400	126,000	-8,400
Chart-Abstracted Measures	85,200	-5,680	42,600	-2,840	42,600	-2,840	42,600	-2,840
Web-Based Measures	3,422	-15,814	2,922	-15,781	2,922	-15,781	2,922	-15,781
Claims-Based Measures	N/A	0	N/A	0	N/A	0	N/A	0
Survey-Based Measures	N/A	0	N/A	0	N/A	0	N/A	0
eCQM Measures	2,350	-157	4,250	-283	4,250	-283	4,250	-283
PRO-PM	13,646,370	1,800,532	13,694,110	1,800,532	13,694,360	1,800,515	13,694,610	1,800,498
Validation	6,000	0	6,613	613	3,627	-2,373	3,627	-2,373
TOTAL	**13,869,342**	**1,770,481**	**13,876,495**	**1,773,841**	**13,873,759**	**1,770,838**	**13,874,009**	**1,770,821**

Table 10. Total Burden Dollars for the CY 2029 through CY 2032 Payment Determinations*

Information Collection	CY 2029	Difference from Currently Approved	CY 2030	Difference from Currently Approved	CY 2031	Difference from Currently Approved	CY 2032	Difference from Currently Approved
Administrative Activities	$7,204,680	($480,312)	$7,204,680	($480,312)	$7,204,680	($480,312)	$7,204,680	($480,312)
Chart-Abstracted Measures	$4,871,736	($324,782)	$2,435,868	($162,391)	$2,435,868	($162,391)	$2,435,868	($162,391)
Web-Based Measures	$195,670	($904,245)	$167,080	($902,358)	$167,080	($902,358)	$167,080	($902,358)
Claims-Based Measures	N/A	$0	N/A	$0	N/A	$0	N/A	$0
Survey-Based Measures	N/A	$0	N/A	$0	N/A	$0	N/A	$0
eCQM Measures	$134,373	($8,977)	$243,015	($16,182)	$243,015	($16,182)	$243,015	($16,182)
PRO-PM	$362,478,207	$47,820,109	$363,746,182	$47,820,109	$363,760,477	$47,819,137	$363,774,772	$47,818,165
Validation	$343,080	$0	$378,150	$35,070	$207,373	($135,707)	$207,373	($135,707)
TOTAL	**$375,227,746**	**$46,101,793**	**$374,174,975**	**$46,293,937**	**$374,018,492**	**$46,122,187**	**$374,032,787**	**$46,121,215**

* 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)

While we assume the majority of HOPDs will report data for the Hospital-Level THA/TKA PRO-PM measure via CMS' HQR System, we assume some HOPDs may elect to submit measure data via a third-party 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 hospital and data vendors, calculation of claims-based measures and validation, measure development and maintenance, the provision of hospitals with feedback and preview reports, as well as costs associated with public reporting. These costs are estimated at $10,050,000 annually for the validation and quality reporting contracts. Additionally, this program requires one CMS staff at a GS-13 Step 5 level to operate. GS-13 Step 5 approximate annual salary is $138,024 plus benefits (30 percent) of $41,407 for a total cost of $179,431. The total annual cost to the Federal Government is $10,229,431.

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

15. Program or Burden Changes

We previously requested total annual burden estimates under this OMB control number for the CY 2027 reporting period/CY 2029 payment determination of 12,098,861 hours at a cost of $317,571,647 as a result of policies finalized in the CY 2026 OPPS/ASC final rule. Accounting for updated wage rates, the total cost of $317,571,647 increases to $329,125,953. For the CY 2027 reporting period/CY 2029 payment determination, based on the proposed measure removals and updates to validation requirements in the CY 2027 OPPS/ASC proposed rule, we estimate a total burden of 13,869,342 hours at a cost of $375,227,746 (an increase of 1,770,481 hours and $46,101,793 from our previous request). This burden estimate also represents an increase of 10,643,296 hours from the currently approved burden estimate of 3,226,046 hours for the CY 2026 reporting period/CY 2028 payment determination.

The proposed removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure would result in a total estimated burden decrease of 15,586 hours at a cost of $891,207 beginning with the CY 2029 payment determination. The proposed updates to validation requirements would result in a total estimated burden decrease of 2,373 hours at a savings of $135,707 beginning with the CY 2031 payment determination. Adjustments to the number of patients surveyed for the Information Transfer PRO-PM based on more recent data

result in an increase of 1,800,532 hours at a cost of $47,822,130. Lastly, our revised estimate of the number of HOPDs results in a decrease in burden of 11,752 hours and $674,001.

The aggregate increase due to these proposed measure removals, updated validation requirements, and revised assumptions as reflected in our burden estimates for the CY 2032 payment determination is 1,770,821 hours (-15,586 – 2,373 + 1,800,532 – 11,752) and $46,121,215 (-$891,207 - $135,707 + $47,822,130 - $674,001) as shown in Tables 9 and 10.

16. Publication

As required by authorizing statute, quality measure data are made publicly available after providing HOPDs the opportunity to review their data. Hospital data from these initiatives are currently used to populate the Compare tool and CMS' Provider Data Catalog available at data.cms.gov. One of the goals of the Hospital Outpatient Quality Reporting Program is to publicly display on all measures adopted for the Program. Data are presented on the Compare tool in a format aimed towards consumers, patients, and the general public, providing access to hospital-specific quality measure performance rates along with state and national performance rates. More detailed measure data, including the data used for the Compare tool, are also available to the public as downloadable files on the Provider Data Catalog. Hospital quality data on the Compare tool and the Provider Data Catalog are currently updated on a quarterly basis; however, 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 Hospital Outpatient Quality Reporting Program pages used to document our measure specifications and reporting guidance.

18. Certification Statement

We do not claim 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 use simple random sampling or systematic random sampling applied consistently within a quarter to reduce the number of cases for which to submit data for certain measures.