Supporting Statement – Part A
Quality Measures and Procedures for the Hospital Inpatient Quality Reporting Program for the FY 2026 IPPS Annual Payment Updates (OMB Control No. 0938-1022)
FY 2024 IPPS/LTCH PPS Proposed Rule (RIN 0938-AV08, CMS-1785-P)

A. Background

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

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

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

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 hosted by HHS or its successor website(s) 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.

Hospitals that do not treat specified conditions or that do not have treatment locations defined for certain of the National Healthcare Safety Network's healthcare-associated infection (HAI) measures (Central Line-Associated Bloodstream Infections (CLABSI), Catheter-associated Urinary Tract Infections (CAUTI), and Surgical Site Infection) have the option to either complete the enrollment process with National Healthcare Safety Network (NHSN) and indicate that they do not have patients who meet the measure requirements, or submit a CMS IPPS Quality Reporting Programs Measure Exception Form for PC and HAI Data Submission. This Measure Exception Form reduces the burden of completing the entire NHSN enrollment process or entering zero denominator information for inapplicable measures for the hospitals that meet the exception requirements.

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

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

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

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

Program. Hospitals may review and request recalculation of their hospital's performance scores on each condition, domain, and TPS using the Hospital VBP Program Review and Corrections Request Form within 30 calendar days of the posting date of the Value-Based Percentage Payment Summary Report. Hospitals may submit an appeal using the Hospital VBP Program Appeal Request Form within 30 calendar days of the date of receiving an adverse determination from CMS on their review and corrections request. Hospitals may submit a Hospital VBP Program Independent CMS Review Request Form within 30 days after they receive an adverse determination from CMS on their appeal.

1. **Hospital IQR Program Quality Measures**

The FY 2026 APU determination will be based on Hospital IQR Program data reported and supporting forms submitted by hospitals on chart-abstracted measures, patient surveys, and eCQMs for calendar year (CY) 2024 discharges. In an effort to reduce burden, a variety of different data collection mechanisms are employed, with every consideration taken to employ data and data collection systems already in place.

In the FY 2024 IPPS/LTCH PPS proposed rule, we are proposing to add 3 new measures, modify 3 existing measures, and remove 3 measures. Proposed changes are discussed below.

a. Measure Removals in the FY 2024 IPPS/LTCH PPS Proposed Rule Which Affect the Burden for the Hospital IQR Program

In the FY 2024 IPPS/LTCH PPS proposed rule, we are proposing to remove one existing measure which would decrease burden for the Hospital IQR Program, which is discussed in more detail in section 12. Specifically, we are proposing to remove the Elective Delivery measure beginning with the CY 2024 reporting period/FY 2026 payment determination.

b. Updates in the FY 2024 IPPS/LTCH PPS Proposed Rule Which Do Not Affect the Burden for the Hospital IQR Program

In the FY 2024 IPPS/LTCH PPS proposed rule, there are a number of policies which do not affect our previously approved information collection burden estimates. We are proposing to adopt three eCQMs beginning with the CY 2025 reporting period/FY 2027 payment determination: (1) Hospital Harm – Pressure Injury eCQM, (2) Hospital Harm – Acute Kidney Injury eCQM, and (3) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM. We are proposing to modify two measures within the Hospital IQR Program measure set beginning with the performance data from July 1, 2024 through June 30, 2025, impacting the FY 2027 payment determination: the (1) Hybrid Hospital-Wide All-Cause Risk Standardized Mortality measure and (2) the Hybrid Hospital-Wide All-Cause Risk Standardized Readmission measure. We are also proposing to modify the COVID-19 Vaccination Coverage among Healthcare Personnel to reflect the latest Centers for Disease Control and Prevention guidance beginning in the quarter 4 CY 2023 reporting period (burden is accounted for under OMB control number 0920-1317; expiration date March 31, 2026). We are proposing to remove two Medicare FFS claims-based measures: the Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total

Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure beginning with the April 1, 2025 through March 31, 2028 reporting period impacting the FY 2030 payment determination; and the Medicare Spending Per Beneficiary (MSPB)—Hospital measure beginning with the CY 2026 reporting period/FY2028 payment determination. We are proposing to modify the validation targeting criteria to include any hospital with a two-tailed confidence interval that is less than 75 percent and which submitted less than four quarters of data due to receiving an extraordinary circumstances exception (ECE) for one or more quarters beginning with the FY 2027 payment determination.

B. Justification

1. Need and Legal Basis

The Hospital IQR Program was first established to implement Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173), which authorized CMS to pay hospitals that successfully reported quality measures a higher annual update to their payment rates. It builds on a voluntary Inpatient Quality Reporting Program, which remains in effect. Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171) revised the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. This is reflected in sections 1886(b)(3)(B)(viii)(I) and (II) of the Social Security Act, which provide that the APU will be reduced for any "subsection (d) hospital" that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

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

2. Information Users

The information from the Hospital IQR Program is made available to hospitals for their use in internal quality improvement initiatives. CMS provides confidential feedback reports that hospitals may use to assess their performance and operationalize quality improvement activities throughout the quality reporting period. These reports include the data that CMS has collected from the hospital and the hospital's claims, and some also include information about how the hospital's data look relative to the performance of other hospitals. For example, the Facility, State and National (FSN) Report allows hospitals to compare their performance related to a

specific measure during a specific timeframe, to the average performance of other hospitals at the state and national levels.

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

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

Most importantly, this information is available to beneficiaries, as well as to the public, to provide hospital information to assist them in making decisions in choosing their health care providers. CMS sometimes conducts focus groups or market testing prior to publicly reporting hospital quality data on the Compare tool hosted by HHS or its successor website(s) in order to get feedback on ways to make the website more user-friendly. Feedback from these focus groups have helped CMS understand how beneficiaries and consumers use the Compare tool hosted by HHS or its successor website(s). Under emergency circumstances, consumers choose hospitals based on proximity, reputation, prior experience, or their doctor's recommendation. For childbirth or elective hospital admissions, when patients and their family members may have the time and motivation to consider options and engage in informed decision making, they have expressed interest in information such as the provider's track record in treating their condition, safety and infection rates, and a hospital's recognized areas of expertise, as well as to take into consideration their doctor's recommendation.

3. Use of Information Technology

To assist hospitals in standardizing data collection initiatives across the industry, CMS continues to improve data collection tools in order to make data submission easier for hospitals (e.g., the automated collection of electronic patient data in electronic health records (EHRs) for eCQMs and hybrid measures, the collection of data from paper or electronic medical records for chart-abstracted measures, or the collection of data from federal registries like the NHSN), as well as to increase the utility of the data provided by the hospitals.

For the claims-based measures or measures which collect data from claims 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 Similar Information

The information to be collected is not duplicative of similar information collected by CMS. We prioritize efforts to reduce reporting burden for the collection of quality of care information by utilizing electronic data that hospitals already report to The Joint Commission for accreditation, as well as aligning eCQMs and related reporting requirements with the Medicare Promoting Interoperability Program for Eligible Hospitals and CAHs.

5. Small Business

Information collection requirements were designed to allow maximum flexibility specifically to small hospitals wishing to participate in hospital reporting. This effort will assist small hospitals in gathering information for their own quality improvement efforts. We define a "small hospital" as one with 1-99 inpatient beds. The Hospital IQR Program included approximately 942 participating IPPS small hospitals in the FY 2023 program year.

6. Less Frequent Collection

We have designed the collection of quality measure data to be the minimum necessary for data validation and for calculation of summary figures to be used as reliable estimates of hospital performance. Frequency of data collection may vary (monthly, quarterly, annually, etc.) based on how a quality measure is specified. The following table details the frequency of data submission to CMS by measure type.

Measure Type	*Frequency of Data Submission*
Chart-abstracted clinical process of care	Quarterly
Online reporting of structural and process measures	Annually
EHR-based (e.g., eCQMs, hybrid measures)	Annually
Online reporting of Patient Reported Outcome-Performance Measures (PRO-PMs)	Semi-annually

7. Special Circumstances

Although participation in the Hospital IQR Program is voluntary on the part of subsection (d) hospitals, all eligible hospitals must submit these data and meet all other Hospital IQR Program requirements in order to receive their full APU for the given fiscal year. If a hospital does not submit the required data and meet all other Hospital IQR Program requirements, it would be subject to a reduced APU for a given fiscal year.

8. *Federal Register* Notice/Outside Consultation

A 60-day *Federal Register* notice of the FY 2024 IPPS/LTCH PPS proposed rule (RIN 0938-AV08, CMS-1785-P) was published on May 1, 2023 (88 FR 26658).

CMS is supported in this initiative by The Joint Commission, the current consensus-based entity, Centers for Disease Control and Prevention (CDC), and Agency for Healthcare Research and Quality (AHRQ). These organizations collaborate with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making the information accessible, understandable, and relevant to the public.

9. Payment/Gift to Respondent

No payments or gifts will be given to respondents for participation.

10. Confidentiality

All information collected under this initiative will be maintained in strict accordance with statutes and regulations governing confidentiality requirements for Quality Improvement Organizations, 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 the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. The CMS clinical data warehouse also voluntarily meets or exceeds the HIPAA standards.

11. Sensitive Questions

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 the case-specific data. These sensitive data will not, however, be released to the public. Only hospital-specific data will be released to the public after consent has been received from the hospital for the release. The patient-specific data remaining in the CMS clinical data warehouse after the data are aggregated for release for public reporting will continue to be subject to the strict confidentiality regulations in 42 CFR Part 480.

12. Burden Estimate (Total Hours & Wages)

a. Background

Our currently approved burden estimates are based on an assumption of approximately 3,150 IPPS hospitals and 1,350 non-IPPS hospitals. For the purposes of burden estimation, we assume all of the activities associated with the Hospital IQR Program for 3,150 IPPS hospitals and 1,350 non-IPPS hospitals will be completed by Medical Records and Health Information Technicians, with the exception of survey completion which will be completed by patients. These staff are qualified to complete the tasks associated with the chart-abstraction of patient data from medical

records, the submission of electronic data from EHRs, the submission of data to clinical registries, and the completion of any of the other applicable forms associated with activities related to the Hospital IQR Program.

As shown in Table 1, OMB has currently approved 1,772,318 hours at a cost of approximately $73.4 million (adjusted for updated wage rates) under OMB control number 0938-1022, accounting for information collection burden experienced by approximately 3,150 IPPS hospitals and 1,150 non-IPPS hospitals for the FY 2025 payment determination. Our burden estimates exclude burden associated with the NHSN under OMB control number 0920-0666 (expiration date January 31, 2025), the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey under OMB control number 0938-0981 (expiration date September 30, 2024), and the Health Insurance Common Claims Form and Supporting Regulations under OMB control number 0938-1197 (expiration date October 31, 2023).

We are not proposing any changes to the currently approved burden estimates for the sepsis chart-abstracted measure, the Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) and Hospital-Wide Mortality (Hybrid HWM) measures, the Maternal Morbidity Structural Measure, population and sampling for ongoing measure sets, reviewing of reports for claims-based measure sets, and completion of all other forms used in the data collection process for the FY 2026 through FY 2029 payment determination years.

Table 1. Currently Approved Burden Estimates for the Hospital IQR Program Measure Set and Other Activities for the FY 2025 Payment Determination

Measure Set	*Estimated time per record (minutes) - FY 2025 payment determination*	*Number reporting quarters per year - FY 2025 payment determination*	*Number of respondents*	*Average number records per hospital per quarter*	*Annual burden (hours) per hospital*	*Calculation for FY 2025 payment determination*
CHART ABSTRACTION						
IPPS Hospitals (3,150)						
Sepsis Measure	60	4	3,150	100	400	1,260,000
Elective Delivery (PC-01)	10	4	3,150	76	51	159,600
Non-IPPS Hospitals (1,350)						
Sepsis measure	60	4	362	25	100	36,200
Elective Delivery (PC-01)	10	4	334	21	14	4,676
Chart Abstracted Measure Subtotal (IPPS and Non-IPPS)						**1,460,476**
HYBRID MEASURES						
IPPS Hospitals (3,150)						
Hybrid HWR Measure	10	4	3,150	1	0.67	2,100

Hybrid HWM Measure	10	4	3,150	1	0.67	2,100
Non-IPPS Hospitals (1,350)						
Hybrid HWR Measure	10	4	1,350	1	0.67	900
Hybrid HWM Measure	10	4	1,350	1	0.67	900
Hybrid Measure Subtotal (IPPS and Non-IPPS)						**6,000**
STRUCTURAL MEASURES						
IPPS Hospitals (3,150)						
Maternal Morbidity Measure	5	1	3,150	1	0.083	263
Hospital Commitment to Health Equity Measure	10	1	3,150	1	0.167	525
Non-IPPS Hospitals (1,350)						
Maternal Morbidity Measure	5	1	1,350	1	0.083	112
Hospital Commitment to Health Equity Measure	10	1	1,350	1	0.167	225
Structural Measure Subtotal (IPPS and Non-IPPS)						**1,125**
REPORTING eCQMs						
IPPS Hospitals (3,150)						
Reporting 4 eCQMs	40	4	3,150	1	2.67	8,400
Non-IPPS Hospitals (1,350)						
Reporting 4 eCQMs	40	4	1,350	1	2.67	3,600
eCQM Subtotal (IPPS and Non-IPPS)						**12,000**
PROCESS MEASURES						
IPPS Hospitals (3,150)						
Screening for Social Drivers of Health Measure (Survey)	0.033	1	5,250,000	1	111.11	175,000
Screening for Social Drivers of Health Measure (Reporting)	10	1	1,575	1	0.167	263
Screen Positive Rate for Social Drivers of Health Measure	10	1	1,575	1	0.167	263
Non-IPPS Hospitals (1,350)						
Screening for Social Drivers of Health Measure (Survey)	0.033	1	2,250,000	1	111.11	75,000
Screening for Social Drivers of Health Measure (Reporting)	10	1	675	1	0.167	112
Screen Positive Rate for Social Drivers of Health Measure	10	1	675	1	0.167	112

Process Measures Subtotal (IPPS and Non-IPPS)						**250,750**
PRO-PM MEASURES						
IPPS Hospitals (3,150)						
Survey	7.25	N/A	20,625	N/A	1.11	2,492
Reporting	10	2	1,575	1	0.33	525
Non-IPPS Hospitals (1,350)						
Survey	7.25	N/A	*	N/A	1.11	*
Reporting	10	2	675	1	0.33	225
PRO-PM Measures Subtotal						**3,242**
OTHER ACTIVITIES **All Hospitals (3,150 IPPS + 1,350 non-IPPS)**						
Population and sampling for the ongoing measure sets	15	4	4,500	4	4	18,000
Review reports for claims-based measure sets	60	4	4,500	1	4	18,000
eCQM Validation	10	3	400	8	4	1,600
All other forms used in the data collection process and structural measures	15	1	4,500	1	0.25	1,125
Subtotal other activities					**12.25**	**38,725**
Total Burden Hours						**1,772,318**
Total Burden for Surveys @ Average Individual Labor rate (252,492 hours x $20.71/hr)						**$5,229,113**
Total Burden @ Medical Records Specialist labor rate (1,519,826 hours x $44.86/hr)						**$68,179,397**
Total Burden						**$73,408,510**

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

Changes to currently approved burden estimates due to policies in the FY 2024 IPPS/LTCH PPS proposed rule are discussed below.

b. Updated Hourly Wage Rate

In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 49385), we estimated that the labor performed could be accomplished by Medical Records and Health Information Technician staff based on a mean hourly wage in general medical and surgical hospitals of $21.20 per hour. We note that since then and as of the publication date of the FY 2024 IPPS/LTCH PPS proposed rule, this Bureau of Labor Statistics occupation category has been replaced with medical record specialists and more recent wage data reflecting a median hourly wage of $22.43 per hour.[1] We calculated the cost of overhead, including fringe benefits, at 100% of the mean hourly wage, consistent with previous years. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly between employers, and because methods of estimating these costs vary widely in the literature. Nonetheless, we believe that doubling the

[1] U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed on January 13, 2023. Available at: https://www.bls.gov/oes/current/oes292072.htm.

hourly wage ($22.43 × 2 = $44.86) to estimate total cost is a reasonably accurate estimation method. As a result of the availability of this more recent wage data, we have updated the wage rate used in these calculations in the FY 2024 IPPS/LTCH PPS proposed rule and this corresponding PRA package to $44.86.

c. Chart-Abstracted Measure Reporting and Submission Requirements for the CY 2024 Reporting Period/FY 2026 Payment Determination and Subsequent Years

In the FY 2024 IPPS/LTCH PPS proposed rule, we are proposing to remove the Elective Delivery (PC-01) measure beginning with the CY 2024 reporting period/FY 2026 payment determination.

As shown in Table 1 for the FY 2025 payment determination, we currently estimate the information collection burden associated with the reporting of chart-abstracted measures to be 60 minutes or 1 hour per record for the sepsis measure and 10 minutes or 0.167 hours per record for the Elective Delivery (PC-01) measure. For the proposed removal of the Elective Delivery measure, we estimate a burden decrease of 51 hours (0.167 hours/record x 76 records x 4 quarters) per IPPS hospital and total of 159,600 hours (51 hours x 3,150 IPPS hospitals) across all IPPS hospitals. We also estimate a burden decrease of 14 hours (0.167 hours/record x 21 records x 4 quarters) per non-IPPS hospital and total of 4,676 (51 hours x 334 non-IPPS hospitals) across all participating non-IPPS hospitals.

We continue to assume that each IPPS hospital will report 100 records quarterly for the sepsis measure for a total annual burden of 400 hours (1 hour/record x 100 records x 4 quarters) per IPPS hospital. We estimate an annual burden of 1,260,000 hours (400 hours/hospital x 3,150 IPPS hospitals) at a cost of $56,523,600 (1,260,000 hours x $44.86/hour) across all IPPS hospitals. We also estimate an annual burden of 36,200 hours (100 hours/hospital x 362 non-IPPS hospitals) at a cost of $1,623,932 (36,200 hours x $44.86/hour) across all participating non-IPPS hospitals.

d. eCQM Reporting and Submission Requirements for the CY 2024 Reporting Period/FY 2026 Payment Determination, and Subsequent Years

In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58974 through 58975), we finalized a policy requiring hospitals to report four quarters of data beginning with the CY 2023 reporting period/FY 2025 payment determination and for subsequent years, while continuing to require hospitals to report three self-selected eCQMs and the Safe Use of Opioids—Concurrent Prescribing eCQM (for a total of four eCQMs). In the FY 2023 IPPS/LTCH PPS final rule, we finalized an increase to the total number of eCQMs to be reported from four to six eCQMs beginning with the CY 2024 reporting period/FY 2026 payment determination, and added the Cesarean Birth and Severe Obstetric Complications eCQMs as eCQMs hospitals are required to report.

For the CY 2024 reporting period/FY 2026 payment determination and subsequent years, we estimate the information collection burden associated with the eCQM reporting and submission requirements to be 60 minutes or 1 hour per hospital per quarter (10 minutes x 6 eCQMs = 1

hour) with a total burden estimate of 3,150 hours across all IPPS hospitals (1 hour × 3,150 IPPS hospitals) for each quarter of eCQM data. We therefore estimate a total burden of 12,600 hours (3,150 hours/quarter x 4 quarters) at a cost of $565,236 (12,600 hours x $44.86/hour) for reporting four quarters of eCQM data for all IPPS hospitals. We also estimate a total burden of 5,400 hours (1,350 hours/quarter x 4 quarters) at a cost of $242,244 (5,400 hours x $44.86/hour) for reporting four quarters of eCQM data for all non-IPPS hospitals.

In the FY 2024 IPPS/LTCH PPS proposed rule, we are proposing to adopt three eCQMs beginning with the CY 2025 reporting period/FY 2027 payment determination: (1) Hospital Harm – Pressure Injury eCQM, (2) Hospital Harm – Acute Kidney Injury eCQM, and (3) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM. We do not believe that our proposed addition of these three eCQMs to the eCQM measure set will affect the information collection burden of submitting eCQMs under the Hospital IQR Program. While this proposal would result in new eCQMs being added to the Hospital IQR Program measure set, hospitals would not be required to report more than a total of six eCQMs for the CY 2024 reporting period/FY 2026 payment determination and subsequent years.

Table 2. Estimated Burden for the eCQM Reporting and Submission Requirements for the FY 2026 through FY 2029 Payment Determination Years

eCQM Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 2026 through FY 2029 Payment Determination Years						
Reporting 6 eCQMs (IPPS Hospitals)	60	4	3,150	1	4	12,600
Reporting 6 eCQMs (Non-IPPS Hospitals)	60	4	1,350	1	4	5,400
Total Burden Hours						**18,000**
Total Burden @ Medical Records Specialist labor rate ($44.86/hr)						**$807,480**

e. Structural Measure Reporting and Submission Requirements for the CY 2024 Reporting Period/FY 2026 Payment Determination and Subsequent Years

We are not proposing any changes to the reporting or submission requirements for the Maternal Morbidity Structural Measure in the FY 2024 IPPS/LTCH PPS proposed rule. In the FY 2022 IPPS/LTCH PPS final rule, we adopted the Maternal Morbidity Structural Measure beginning with the CY 2021 reporting period/FY 2023 payment determination and for subsequent years. Reporting on the Maternal Morbidity Structural Measure involves each hospital responding to a single question using a web-based tool available via Hospital Quality Reporting (HQR) System (formerly referred to as the QualityNet Secure Portal) with one of the following response

options: (A) "Yes"; (B) "No"; or (C) "N/A (our hospital does not provide inpatient labor/delivery care)." Hospitals are required to submit responses for this structural measure on an annual basis during the submission period. As shown in Table 3, using the estimate of 5 minutes (or 0.083 hours) per hospital per year and the updated wage estimate as described previously, we estimate an annual burden of 263 hours across all IPPS hospitals (0.083 hours × 3,150 IPPS hospitals) at a cost of $11,776 (263 hours × $44.86/hour) and an annual burden estimate of 112 hours across all non-IPPS hospitals (0.083 hours x 1,350 non-IPPS hospitals) at a cost of $5,047 (112 hours x $44.86/hour).

In the FY 2023 IPPS/LTCH PPS final rule, we finalized the Hospital Commitment to Health Equity structural measure beginning with the CY 2023 reporting period/FY 2025 payment determination and for subsequent years. We require hospitals to submit the response on an annual basis during the submission period via the HQR System. We estimate the information collection burden associated with this structural measure to be, on average across all 3,150 IPPS hospitals, no more than 10 minutes per hospital per year, as it involves attesting to as many as five questions one time per year for a given reporting period. As shown in Table 3, using the estimate of 10 minutes (or 0.167 hours) per hospital per year and the updated wage estimate as described previously, we estimate an annual burden of 525 hours across all IPPS hospitals (0.167 hours × 3,150 IPPS hospitals) at a cost of $23,552 (525 hours × $44.86/hour) and an annual burden of 225 hours across all non-IPPS hospitals (0.167 hours × 1,350 non-IPPS hospitals) at a cost of $10,094 (225 hours × $44.86/hour).

Table 3. Estimated Burden for Structural Measure Reporting for the FY 2026 through FY 2029 Payment Determination Years

Structural Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per hospital per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all hospitals***
FY 2026 through FY 2029 Payment Determination Years						
Maternal Morbidity Measure (IPPS Hospitals)	5	1	3,150	1	0.083	263
Maternal Morbidity Measure (Non-IPPS Hospitals)	5	1	1,350	1	0.083	112
Total Burden Hours						**375**
Hospital Commitment to Health Equity Measure (IPPS Hospitals)	10	1	3,150	1	0.167	525
Hospital Commitment to Health Equity Measure (Non-IPPS Hospitals)	10	1	1,350	1	0.167	225

Total Burden Hours	**750**
Total Burden @ Medical Records Specialist labor rate ($44.86/hr)	**$50,468**

f. Hybrid Measure Reporting and Submission Requirements for the CY 2024 Reporting Period/FY 2026 Payment Determination and Subsequent Years

We are not finalizing any changes to the reporting or submission requirements for the Hybrid HWR and Hybrid HWM measures in the FY 2024 IPPS/LTCH PPS proposed rule. We are however, proposing to modify both the Hybrid HWR and Hybrid HWM measures beginning with the performance data from July 1, 2024 through June 30, 2025, impacting the FY 2027 payment determination. These proposed modifications would expand the cohort of the measures from only Medicare fee-for-service (FFS) patients to a cohort which includes both FFS and Medicare Advantage (MA) patients 65 to 94 years old. Although the proposed modifications of both measures would expand the measure cohort to include MA patients, the burden associated with submission of claims data continues to be accounted for under OMB control number 0938-1197 (expiration date October 31, 2023) and the burden associated with submission of eCQM data under OMB control number 0938-1022 remains unchanged as hospitals will not be required to submit any additional data. Therefore, we are not proposing any changes in burden associated with the proposed modifications of these measures.

In the FY 2020 IPPS/LTCH PPS final rule, we adopted the Hybrid HWR measure (84 FR 42505 through 42508). In the FY 2022 IPPS/LTCH PPS final rule, we adopted the Hybrid HWM measure. As shown in Table 4, we continue to estimate the information collection burden associated with these measures will be 10 minutes per measure per quarter for each hospital. We estimate the total annual burden to be 1.33 hours per hospital (10 minutes/quarter x 2 measures x 4 quarters) at a cost of $59.81 (1.33 hours x $44.86/hour) for each hospital. The total annual burden for all 3,150 IPPS hospitals is estimated to be 4,200 hours (1.33 hours/hospital x 3,150 hospitals) at a cost of $188,412 (4,200 hours x $44.86/hour). The total annual burden for all 1,350 non-IPPS hospitals is estimated to be 1,800 hours (1.33 hours/hospital x 1,350 hospitals) at a cost of $80,748 (1,800 hours x $44.86/hour).

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

Table 4. Estimated Burden for Hybrid Measure Reporting and Submission Requirements for the FY 2026 through FY 2029 Payment Determination Years

Hybrid Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of hospitals reporting***	***Average number records per***	***Annual burden (hours)***	***Total Annual Hours for all hospitals***

				hospital per quarter	***per hospital***	
FY 2026 through FY 2029 Payment Determination Years						
Hybrid HWR Measure (IPPS Hospitals)	10	4	3,150	1	0.67	2,100
Hybrid HWR Measure (Non-IPPS Hospitals)	10	4	1,350	1	0.67	900
Total Burden Hours						**3,000**
Hybrid HWM Measure (IPPS Hospitals)	10	4	3,150	1	0.67	2,100
Hybrid HWM Measure (Non-IPPS Hospitals)	10	4	1,350	1	0.67	900
Total Burden Hours						**3,000**
Total Burden @ Medical Records Specialist labor rate ($44.86/hr)						**$269,160**

g. Process Measure Reporting and Submission Requirements for the CY 2024 Reporting Period/FY 2026 Payment Determination and Subsequent Years

We are not finalizing any changes to the reporting or submission requirements for the process measures in the FY 2024 IPPS/LTCH PPS proposed rule. In the FY 2023 IPPS/LTCH PPS final rule, we adopted the Screening for Social Drivers of Health and the Screen Positive Rate for Social Drivers of Health process measures (87 FR 49385 through 49386).

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

To estimate the cost of patient screening, we previously used data from the Bureau of Labor Statistics, which reflects an Average Hourly Earnings of $31.31/hour. Per updated guidance, we are updating our methodology and believe that the cost for beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $20.71/hour[2]. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses:

[2] https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework

Conceptual Framework and Best Practices identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for beneficiaries, a measurement of the usual weekly earnings of wage and salary workers of $998, divided by 40 hours to calculate an hourly pre-tax wage rate of $24.95/hour. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in the post-tax hourly wage rate of $20.71/hour. Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

Based on information collected by the American Hospital Association,[3] we estimate approximately 19,250,000 patients (31,393,318 total admissions in U.S. community hospitals x 3,150 IPPS hospitals ÷ 5,139 total U.S. community hospitals) will be screened annually across all participating IPPS hospitals and approximately 8,250,000 patients (31,393,318 total admissions in U.S. community hospitals x 1,350 IPPS hospitals ÷ 5,139 total U.S. community hospitals). For the CY 2024 reporting period and subsequent years, we estimate a total annual burden of 641,667 hours (19,250,000 respondents x 0.033 hours) at a cost of $13,288,917 (641,667 hours x $20.71/hour) across all IPPS hospitals. We also estimate a total annual burden of 275,000 hours (8,250,000 respondents x 0.033 hours) at a cost of $5,695,250 (275,000 hours x $20.71/hour) across all non-IPPS hospitals.

Measure data aggregated at the hospital level will be submitted via the HQR System annually. Similar to the currently approved data submission and reporting burden estimate for eCQMs in the Hospital IQR Program reported via the HQR System, we estimate a burden of 10 minutes per hospital response to transmit the measure data. We estimate that during the voluntary period, 50 percent of hospitals will submit data. For the CY 2024 reporting period and subsequent years, we estimate a total annual burden for all IPPS hospitals of 525 hours (0.1667 hours x 3,150 IPPS hospitals) at a cost of $23,552 (525 hours x $44.86/hour). We also estimate a total annual burden for all non-IPPS hospitals of 225 hours (0.1667 hours x 1,350 non-IPPS hospitals) at a cost of $10,094 (225 hours x $44.86/hour).

For the Screen Positive Rate for Social Drivers of Health measure, hospitals will be required to report on an annual basis the number of patients who screen positive for one or more of the five domains divided by the total number of patients screened (reported as five separate rates). For this measure, we estimate only the additional burden for a hospital reporting this measure via the HQR System since patients will not need to provide any additional information for this measure. For the CY 2024 reporting period and subsequent years, we estimate a total annual burden estimate for all participating IPPS hospitals of 525 hours (0.1667 hours/measure x 3,150 hospitals) at a cost of $23,552 (525 hours x $44.86/hour). We also estimate a total annual burden estimate for all non-IPPS hospitals of 225 hours (0.1667 hours/measure x 1,350 non-hospitals) at a cost of $10,094 (225 hours x $44.86/hour).

Table 5. Estimated Burden for the Process Measures Reporting and Submission Requirements for the FY 2026 through FY 2029 Payment Determination Years

Process Measure Reporting	*Estimated time per*	*Number reporting*	*Number of respondents*	*Average number*	*Annual burden*	

[3] https://www.aha.org/statistics/fast-facts-us-hospitals

	record (minutes)	*quarters per year*		*records per respondent per quarter*	*(hours) per hospital*	*Total Annual Hours for all respondents*
FY 2026 through FY 2029 Payment Determination Years						
Screening for Social Drivers of Health Measure (Survey) (Patients in IPPS Hospitals)	0.033	1	19,250,000	1	203.7	641,667
Screening for Social Drivers of Health Measure (Reporting) (IPPS Hospitals)	10	1	3,150	1	0.167	525
Screening for Social Drivers of Health Measure (Survey) (Patients in Non-IPPS Hospitals)	0.033	1	8,250,000	1	203.7	275,000
Screening for Social Drivers of Health Measure (Reporting) (Non-IPPS Hospitals)	10	1	1,350	1	0.167	225
Total Burden Hours						**917,417**
Total Burden @ Average Individual labor rate ($20.71/hr)						**$18,984,167**
Total Burden @ Medical Records Specialist labor rate ($44.86/hr)						**$33,645**
Screen Positive Rate for Social Drivers of Health Measure (IPPS Hospitals)	10	1	3,150	1	0.167	525
Screen Positive Rate for Social Drivers of Health Measure (Non-IPPS Hospitals)	10	1	1,350	1	0.167	225
Total Burden Hours						**750**
Total Burden @ Medical Records Specialist labor rate ($44.86/hr)						**$33,645**

h. Patient-Reported Outcomes-Based Performance Measure (PRO-PM) Reporting and Submission Requirements for the CY 2024 Reporting Period/FY 2026 Payment Determination and Subsequent Years

In the FY 2023 IPPS/LTCH PPS final rule, we adopted the Hospital-Level THA/TKA PRO-PM measure (87 FR 49386 through 49387). The Hospital-Level THA/TKA PRO-PM uses four sources of data for the calculation of the measure: (1) Patient-reported outcome (PRO) data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. We estimate no additional burden associated with claims data, Medicare enrollment and

beneficiary data, and U.S. Census Bureau survey data as these data are already collected via other mechanisms.

Hospitals have multiple options for when and how they collect PRO data so they can best determine the mode and timing of collection that works best for their patient population. The possible patient touchpoints for pre-operative PRO data collection include the doctor's office, pre-surgical steps such as education classes, or medical evaluations that can occur in an office or at the hospital. The modes of PRO data collection can include completion of the pre-operative surveys using electronic devices (such as an iPad or tablet), pen and paper, mail, phone call, or through the patient's portal. Post-operative PRO data collection modes are similar to pre-operative modes. The possible patient touchpoints for post-operative data collection can occur before the follow-up appointment, at the doctor's office, or after the follow-up appointment. The potential modes of PRO data collection for post-operative data are the same as for pre-operative data. If the patient does not or cannot attend a follow-up appointment, the modes of collection can include completion of the post-operative survey using email, mail, phone, or through the patient portal. Use of multiple modes can increase response rates as it allows for different patient preferences.

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

Under OMB control number 0938-0981 (expiration date September 30, 2024), the currently approved burden per respondent to complete the HCAHPS Survey is 7.25 minutes (0.121 hours). We estimate that the time to complete both the pre-operative and post-operative surveys is analogous to completing the HCAHPS Survey once. To estimate the cost of patients completing the surveys, we previously used data from the Bureau of Labor Statistics reflects an Average Hourly Earnings of $31.31/hour. Per updated guidance, we are updating our methodology and believe that the cost for beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $20.71/hour. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for beneficiaries, a measurement of the usual weekly earnings of wage and salary workers of $998, divided by 40 hours to calculate an hourly pre-tax wage rate of $24.95/hour. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in the post-tax hourly wage rate of $20.71/hour. Unlike our State and private sector wage adjustments, we are not adjusting

beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

For burden estimation purposes, we assume that most hospitals will likely undertake PRO data collection through a screening tool incorporated into their EHR or other patient intake process. We estimate that approximately 330,000 THA/TKA procedures occur in the inpatient setting each year, and that many patients could complete both the pre-operative and post-operative questionnaires, although from our experience with using this measure in the Comprehensive Joint Replacement model, we are also aware that not all patients who complete the pre-operative questionnaire would complete the post-operative questionnaire. Due to the performance period for the first voluntary reporting period being 6 months, we assume 41,250 patients will complete the survey (165,000 patients x 50 percent x 50 percent of hospitals) for a total of 4,984 hours annually (41,250 respondents x 0.121 hours) at a cost of $103,226 (4,984 hours x $20.71) across all participating IPPS and non-IPPS hospitals. For the second voluntary reporting period, we assume 82,500 patients will complete the survey (330,000 patients x 50 percent x 50 percent of hospitals) for a total of 9,969 hours annually (82,500 respondents x 0.121 hours) at a cost of $206,453 (9,969 hours x $20.71/hour) across all participating IPPS and non-IPPS hospitals. Beginning with mandatory reporting for the FY 2028 payment determination, we estimate a total of 39,875 hours (330,000 patients x 0.121 hours) at a cost of $825,811 (39,875 hours x $20.71/hour) across all IPPS and non-IPPS hospitals. Due to the voluntary and mandatory performance periods occurring across reporting periods, we have included Table 6 below to allow for easier understanding of how many procedures (and therefore how many surveys) are estimated to be conducted during each reporting period.

We are not able to accurately distinguish the number of procedures that take place in IPPS hospitals from those conducted in non-IPPS hospitals. As a result, we combine the burden associated with completion of the pre-operative and post-operative surveys in Table 7.

Table 6. Estimated Number of THA/TKA PRO-PM Surveys Conducted in the CY 2023 through CY 2026 Reporting Periods

Reporting Period	Performance Period	Number of Procedures	Minutes per Survey	Burden Hours	Total Burden
CY2023	1st Voluntary Period	20,625	7.25	2,492	**2,492**
CY2024	1st Voluntary Period	20,625	7.25	2,492	**7,477**
CY2024	2nd Voluntary Period	41,250	7.25	4,984	
CY2025	2nd Voluntary Period	41,250	7.25	4,984	**24,922**
CY2025	Mandatory Period	165,000	7.25	19,938	
CY2026	Mandatory Period	330,000	7.25	39,875	**39,875**

For the data submission, which is reported via the HQR System, we estimate a burden of 10 minutes per response. For each of the two voluntary reporting periods, we estimate that each

hospital will spend 20 minutes (0.33 hours) annually (10 minutes x 2 surveys) to collect and submit the data via this tool. We estimate a resulting burden for all participating IPPS hospitals of 525 hours (0.33 hours x 3,150 IPPS hospitals x 50 percent) at a cost of $23,552 (525 hours x $44.86/hour) and a burden for all participating non-IPPS hospitals of 225 hours (0.33 hours x 1,350 non-IPPS hospitals x 50 percent) at a cost of $10,094 (225 hours x $44.86/hour). Beginning with mandatory reporting for the FY 2028 payment determination, we estimate a total annual burden of 1,050 hours (0.33 hours x 3,150 IPPS hospitals) at a cost of $47,103 (1,050 hours x $44.86/hour) for all IPPS hospitals and a total annual burden of 450 hours (0.33 hours x 1,350 non-IPPS hospitals) at a cost of $20,187 (450 hours x $44.86/hour).

Table 7. Estimated Burden for PRO-PM Measure Reporting and Submission Requirements for the FY 2026 through FY 2029 Payment Determination Years

PRO-PM Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of respondents***	***Average number records per respondent per quarter***	***Annual burden (hours) per hospital***	***Total Annual Hours for all respondents***
FY 2026 Payment Determination						
IPPS and Non-IPPS Hospitals (Survey)	7.25	N/A	61,875	N/A	3.32	7,477
IPPS Hospitals (Reporting)	10	2	1,575	1	0.33	525
Non-IPPS Hospitals (Reporting)	10	2	675	1	0.33	225
Total Burden Hours						**8,227**
Total Burden @ Average Individual labor rate ($20.71/hr)						**$154,840**
Total Burden @ Medical Records Specialist labor rate ($44.86/hr)						**$33,645**
FY 2027 Payment Determination						
IPPS and Non-IPPS Hospitals (Survey; Voluntary)	7.25	N/A	41,250	N/A	2.22	4,984
IPPS and Non-IPPS Hospitals (Survey; Mandatory)	7.25	N/A	165,000	N/A	4.43	19,938
IPPS Hospitals (Voluntary Reporting)	10	1	1,575	1	0.167	263
IPPS Hospitals (Mandatory Reporting)	10	1	3,150	1	0.167	525
Non-IPPS Hospitals (Voluntary Reporting)	10	1	675	1	0.167	112
Non-IPPS Hospitals (Mandatory Reporting)	10	1	1,350	1	0167	225
Total Burden Hours						**26,047**

Total Burden @ Average Individual labor rate ($20.71/hr)						**$516,132**
Total Burden @ Medical Records Specialist labor rate ($44.86/hr)						**$50,468**
FY 2028 through FY 2029 Payment Determination Years						
IPPS and Non-IPPS Hospitals (Survey)	7.25	N/A	330,000	N/A	8.86	39,875
IPPS Hospitals (Reporting)	10	2	3,150	1	0.33	1,050
Non-IPPS Hospitals (Reporting)	10	2	1,350	1	0.33	450
Total Burden Hours						**41,375**
Total Burden @ Average Individual labor rate ($20.71/hr)						**$825,811**
Total Burden @ Medical Records Specialist labor rate ($44.86/hr)						**$67,290**

i. Validation of Hospital IQR Program Measure Data, Population and Sampling for Ongoing Measure Sets, and Reviewing Reports for Claims-Based Measure Sets

We continue to estimate the information collection burden associated with eCQM validation for CY 2024 reporting period/FY 2026 payment determination and subsequent years to be 10 minutes per record for the pool of 400 hospitals selected.

As shown in Tables 8 and 9, for eCQM validation of CY 2023 data impacting the FY 2026 payment determination and for subsequent years, we estimate a total burden of 2,133 hours across 400 IPPS hospitals selected for eCQM validation (0.167 hours × 4 quarters × 8 cases × 400 IPPS hospitals) at a cost of $95,701 ($44.86/hour × 2,133 annual hours).

As shown in Table 1, we continue to estimate the information collection burden associated with population and sampling of ongoing measure sets to be 15 minutes per record per quarter and assume each hospital will report four records for four quarters each year. The total annual burden estimate per hospital is 4 hours (15 minutes/record/quarter x 4 records x 4 quarters) at a cost of $179 ($44.86/hour x 4 hours). For all 4,500 IPPS and non-IPPS hospitals, we estimate a total annual burden of 18,000 hours (4 hours x 4,500 hospitals) at a cost of $807,480 ($44.86/hour x 18,000 hours).

Also as shown in Table 1, we continue to estimate the information collection burden associated with reviewing reports for claims-based measure sets to be 60 minutes per record per quarter and assume each hospital will report one record for four quarters each year. The total annual burden estimate per hospital is 4 hours (60 minutes/quarter x 4 quarters) at a cost of $179 ($44.86/hour x 4 hours). For all 4,500 hospital (IPPS and non-IPPS), we estimate a total annual burden of 18,000 hours (4 hours x 4,500 hospitals) at a cost of $807,480 ($44.86/hour x 18,000 hours).

j. Additional Information on Burden Estimates

Time estimates for activities other than chart-abstraction, including completion of the forms listed below, routine reporting of population and sampling numbers for ongoing chart-abstracted measures, and review of reports were made in consultation with our Hospital IQR Program support contractor, which is responsible for routine interface with hospitals and Quality

Improvement Organizations regarding Hospital IQR Program requirements. We define *"all other forms used in the data collection process"* as the forms listed below. Consistent with estimates in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49762), we estimate a burden of 15 minutes per hospital to complete all applicable forms.

Other than the DACA form, the forms listed in section B.12.l. would not be filled out by hospitals on a regular basis. Because the CMS Quality Reporting Program Extraordinary Circumstances Exceptions (ECE) Request Form would be used across ten quality programs (Hospital IQR Program, Hospital Outpatient Quality Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Hospital VBP Program, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, and End Stage Renal Disease Quality Incentive Program), we have included a burden calculation using this form as an example of "all other forms" within this PRA package. This form is intended to be submitted by participants only in the event of an extraordinary circumstance or disaster if they seek an exception from data reporting requirements due to such extraordinary circumstance. For example, in CY 2021, 184 ECE requests were submitted by hospitals for an exception from reporting requirements in the Hospital IQR Program. Based on our estimation of 15 minutes per record to submit the ECE Request Form, the total burden calculation for the submission of 184 ECE Request Forms was 2,760 minutes (or 46 hours) across 3,150 IPPS hospitals. Note that non-IPPS hospitals do not need this form because they participate in quality data reporting on a voluntary basis. We were conservative in our estimate (provided in Table 1 above) of 1,125 hours across all IPPS and non-IPPS hospitals, thus this 46 hours ECE Request Form burden estimation is accounted for in that figure.

As shown in Table 1, we estimate the information collection burden per hospital associated with completing all other forms used in the data collection process to be 15 minutes (0.25 hours) per year at a cost of $11.22 ($44.86/hour x 0.25 hours). For all 4,500 IPPS and non-IPPS hospitals, we estimate a total annual burden of 1,125 hours (0.25 hours x 4,500 hospitals) at a cost of $50,468 ($44.86/hour x 1,125 hours).

k. Burden Estimate Summary

As shown in Tables 8 and 9, in summary, under OMB control number 0938-1022, we estimate a total annual information collection burden decrease for 4,500 hospitals (IPPS and non-IPPS) of 247,609 hours associated with our proposed policies and updated burden estimates described above and a total cost decrease related to this information collection of approximately $10,121,910 (which also reflects use of updated hourly wage rates as previously discussed), from the CY 2024 reporting period/FY 2026 payment determination through the CY 2027 reporting period/FY 2029 payment determination, compared to our currently approved information collection burden estimates. The tables below summarize the total burden changes for each respective FY payment determination compared to our currently approved information collection burden estimates (the columns in each table for the FY 2029 payment determination reflects the cumulative burden changes).

Table 8. Summary of Annual Burden Hour Estimates for the FY 2025 through FY 2029 Payment Determination Years

	ANNUAL BURDEN HOURS									
Information Collection	**FY2025**	**Difference from Currently Approved**	**FY2026**	**Difference from Currently Approved**	**FY2027**	**Difference from Currently Approved**	**FY2028**	**Difference from Currently Approved**	**FY2029**	**Difference from Currently Approved**
Chart Abstraction										
IPPS	1,419,600	0	1,260,000	-159,600	1,260,000	-159,600	1,260,000	-159,600	1,260,000	-159,600
Non-IPPS	40,876	0	36,200	-4,676	36,200	-4,676	36,200	-4,676	36,200	-4,676
Hybrid Measures										
IPPS	4,200	0	4,200	0	4,200	0	4,200	0	4,200	0
Non-IPPS	1,800	0	1,800	0	1,800	0	1,800	0	1,800	0
Structural Measures										
IPPS	788	0	788	0	788	0	788	0	788	0
Non-IPPS	337	0	337	0	337	0	337	0	337	0
Reporting eCQMs										
IPPS	8,400	0	12,600	0	12,600	0	12,600	0	12,600	0
Non-IPPS	3,600	0	5,400	0	5,400	0	5,400	0	5,400	0
Process Measures										
IPPS	175,525	0	642,717	-58,333	642,717	-58,333	642,717	-58,333	642,717	-58,333
Non-IPPS	75,225	0	275,450	-25,000	275,450	-25,000	275,450	-25,000	275,450	-25,000
PRO-PM Measures										
IPPS	3,017	0	8,002	0	25,710	0	40,925	0	40,925	0
Non-IPPS	225	0	225	0	337	0	450	0	450	0
Population and sampling for the ongoing measure sets	18,000	0	18,000	0	18,000	0	18,000	0	18,000	0
Review reports for claims-based measure sets	18,000	0	18,000	0	18,000	0	18,000	0	18,000	0
eCQM Validation	1,600	0	2,133	0	2,133	0	2,133	0	2,133	0
All other forms used in the data collection process	1,125	0	1,125	0	1,125	0	1,125	0	1,125	0
TOTAL	**1,772,318**	**0**	**2,286,977**	**-247,609**	**2,304,797**	**-247,609**	**2,320,125**	**-247,609**	**2,320,125**	**-247,609**

Table 9. Summary of Annual Burden Cost Estimates for the FY 2025 through FY 2029 Payment Determination Years*

	ANNUAL BURDEN COST									
Information Collection	**FY2025**	**Difference from Currently Approved**	**FY2026**	**Difference from Currently Approved**	**FY2027**	**Difference from Currently Approved**	**FY2028**	**Difference from Currently Approved**	**FY2029**	**Difference from Currently Approved**
Chart Abstraction										
IPPS	$63,683,256	$0	$56,523,600	($7,159,656)	$56,523,600	($7,159,656)	$56,523,600	($7,159,656)	$56,523,600	($7,159,656)
Non-IPPS	$1,833,697	$0	$1,623,932	($209,765)	$1,623,932	($209,765)	$1,623,932	($209,765)	$1,623,932	($209,765)
Hybrid Measures										
IPPS	$188,412	$0	$188,412	$0	$188,412	$0	$188,412	$0	$188,412	$0
Non-IPPS	$80,748	$0	$80,748	$0	$80,748	$0	$80,748	$0	$80,748	$0
Structural Measures										
IPPS	$35,350	$0	$35,350	$0	$35,350	$0	$35,350	$0	$35,350	$0
Non-IPPS	$15,118	$0	$15,118	$0	$15,118	$0	$15,118	$0	$15,118	$0
Reporting eCQMs										
IPPS	$376,824	$0	$565,236	$0	$565,236	$0	$565,236	$0	$565,236	$0
Non-IPPS	$161,496	$0	$242,244	$0	$242,244	$0	$242,244	$0	$242,244	$0
Process Measures										
IPPS	$3,647,802	$0	$13,336,020	($1,926,739)	$13,336,020	($1,926,739)	$13,336,020	($1,926,739)	$13,336,020	($1,926,739)
Non-IPPS	$1,563,344	$0	$5,715,437	($825,750)	$5,715,437	($825,750)	$5,715,437	($825,750)	$5,715,437	($825,750)
PRO-PM Measures										
IPPS**	$75,165	$0	$178,391	$0	$551,459	$0	$872,914	$0	$872,914	$0
Non-IPPS	$10,094	$0	$10,094	$0	$15,118	$0	$20,187	$0	$20,187	$0
Population and sampling for the ongoing measure sets	$807,480	$0	$807,480	$0	$807,480	$0	$807,480	$0	$807,480	$0
Review reports for claims-based measure sets	$807,480	$0	$807,480	$0	$807,480	$0	$807,480	$0	$807,480	$0
eCQM Validation	$71,776	$0	$95,686	$0	$95,686	$0	$95,686	$0	$95,686	$0
All other forms used in the data collection process	$50,468	$0	$50,468	$0	$50,468	$0	$50,468	$0	$50,468	$0
TOTAL	**$73,408,510**	**$0**	**$80,275,696**	**($10,121,910)**	**$80,653,788**	**($10,121,910)**	**$80,980,312**	**($10,121,910)**	**$80,980,312**	**($10,121,910)**

* Cost estimates are based on updated wage rates. Differences from currently approved burden account for updating estimates of currently approved hours to the new wage rates.

** Includes burden associated with surveys completed by patients receiving care at Non-IPPS hospitals (see Section 12.h)

l. Information Collection Instruments/Instructions

- The Hospital Quality Reporting Data Accuracy and Completeness Acknowledgement form is being resubmitted to reflect an added bullet for "electronic health record data elements for hybrid measures"
- The Hospital Compare Request Form for Withholding/Footnoting Data for Public Reporting is being resubmitted to add new measures.
- The CMS IPPS Quality Reporting Programs Measure Exception Form for PC and HAI Data Submission is being resubmitted to reflect its removal from the Hospital IQR Program and continued use in only the Hospital-Acquired Condition (HAC) Reduction Program and Hospital Value-Based Purchasing Program.
- The CMS Quality Program Extraordinary Circumstances Exceptions (ECE) Request Form is being resubmitted to clarify submission deadlines.
- The Hospital IQR Program Maternal Morbidity Structural measure is being resubmitted to add verbiage that the IPPS Measure Exception Form, for PC-01, cannot be used for this measure.
- The eCQM Denominator Declaration is being added to this package. This replicates the data entry form that is within the HQR Secure Portal.

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

- Hospital Inpatient Quality Reporting Notice of Participation
- CMS Quality Reporting Validation Educational Review Form
- CMS Hospital IQR Program Validation Review for Reconsideration Request Form
- CMS Quality Reporting Program Annual Payment Update (APU) Reconsideration Request Form
- Hospital Value-Based Purchasing (VBP) Program Review and Corrections Request Form
- Hospital VBP Appeal Request Form
- Hospital VBP Independent CMS Review Request Form
- CMS Quality Reporting Validation Educational Review Form

13. Capital Costs (Maintenance of Capital Costs)

In order for hospitals to receive a point for each of the five domains in the Hospital Commitment to Health Equity structural measure, affirmative attestations are required for each of the elements within a domain. For hospitals that are unable to attest affirmatively for an element, there are likely to be additional costs associated with activities such as updating hospital policies, engaging senior leadership, participating in new quality improvement activities, performing additional data analysis, and training staff. The extent of these costs will vary from hospital to hospital depending on what activities the hospital is already performing, hospital size, and the

individual choices each hospital makes in order to meet the criteria necessary to attest affirmatively.

For hospitals that are not currently collecting Hospital-Level THA/TKA PRO-PM data, there will be some non-recurring costs associated with changes in workflow and information systems to collect the data. The extent of these costs is difficult to quantify as different hospitals may utilize different modes of data collection (for example paper-based, electronically patient-directed, clinician-facilitated, etc.). While we assume the majority of hospitals will report data for this measure via the HQR System, we assume some hospitals may elect to submit measure data via a third-party CMS-approved survey vendor, for which there are associated costs. Under OMB control number 0938-0981 for the HCAHPS Survey measure (expiration date September 30, 2024), an estimate of approximately $4,000 per hospital is used to account for these costs. This estimate originates from 2012, therefore, to account for inflation (assuming end of CY 2012 to April 2023), we adjust the price using the Bureau of Labor Statistics Consumer Price Index and estimate an updated cost of approximately $5,284 ($4,000 x 132.1 percent).[4]

14. Cost to Federal Government

The cost to the Federal Government includes costs associated with the collection and validation of the data. These costs are estimated at $10,050,000 annually for the validation and quality reporting contracts. Additionally, this program takes three CMS staff at a GS-13 level with approximate annual salaries of $112,015 per staff member to operate for an additional cost of $336,045.

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

15. Program or Burden Changes

We previously requested and received approval for total annual burden estimates under this OMB control number for the CY 2024 reporting period/FY 2026 payment determination of 2,534,586 hours at a total cost of approximately $96.3 million as a result of policies finalized in the FY 2023 IPPS/LTCH PPS final rule. Accounting for updated wage rates and the updated methodology for estimating the cost of patients' time, the total cost of $96.3 million decreases to $90.4 million. For the CY 2024 reporting period/FY 2026 payment determination, based on the proposals promulgated in the FY 2024 IPPS/LTCH PPS proposed rule, we estimate a total burden of 2,286,977 hours and $80,275,696 (a decrease of 247,609 hours and $16,017,817 from our estimate in the FY 2023 IPPS/LTCH PPS proposed rule). However, this burden estimate also represents an increase of 514,659 hours and $7,929,543 from the currently approved burden

[4] U.S. Bureau of Labor Statistics. Historical CPI-U data. Accessed on March 9, 2023. Available at: https://www.bls.gov/cpi/tables/supplemental-files/historical-cpi-u-202304.pdf

estimate of 1,772,318 hours and $72,346,153 for the CY 2023 reporting period/FY 2025 payment determination.

The proposed policy in the FY 2024 IPPS/LTCH PPS proposed rule to remove the Elective Delivery (PC-01) chart abstracted measure beginning with the FY 2026 payment determination results in an annual burden decrease of 164,276 hours and $7,369,421. The use of updated data for the number of inpatient admissions for the Screening for Social Drivers of Heath measure results in a decrease of 83,333 hours and $2,752,489. The aggregate decrease due to these policies and adjustments is 247,609 hours and $10,121,910 as shown in Tables 8 and 9.

16. Publication/Tabulation Data

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

17. Expiration Date

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

18. Certification Statement

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