Supporting Statement – Part A

Collection of Information for the Hospital Outpatient Quality Reporting (OQR) Program: CY 2026 OPPS/ASC Final Rule (OMB# 0938-1109; CMS-10250)

A. Background

This is a revision of a currently approved information collection request. The Centers for Medicare & Medicaid Services' (CMS') quality reporting programs promote higher quality, more efficient health care for 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 in care quality.

CMS has implemented quality reporting programs for multiple settings, including the hospital outpatient setting, as authorized by statute, and seeks to achieve overarching priorities and initiatives promoting quality healthcare as detailed in the Meaningful Measures 2.0 Initiative.[1] Meaningful Measures 2.0 promotes innovation and modernization of all aspects of quality to better address health care priorities, reduce burden, and increase efficiency: (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 to be fully digital and incorporating all-payer data.

Information collection requirements through the calendar year (CY) 2030 payment determination are currently approved under OMB control number 0938-1109 (expiration date January 31, 2026). This request covers data collection requirements for the CY 2027 payment determination and subsequent years for the Hospital OQR Program. This updated information collection request includes changes in burden associated with the removal of the Hospital Commitment to Health Equity (HCHE) measure, the Screening for Social Drivers of Health (SDOH) measure, the Screen Positive Rate for SDOH measure, the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients) measure, and the Left Without Being Seen (LWBS) measure; adoption of the Emergency Care Access & Timeliness eCQM; and modification of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Excessive Radiation) electronic clinical quality measure (eCQM).

B. Justification

1. Need and Legal Basis

The Hospital OQR 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

[1] https://www.cms.gov/medicare/quality/cms-national-quality-strategy/meaningful-measures-20-moving-measure-reduction-modernization

2006[2] 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.

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 (IQR) 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 authorizing legislation to collect and make publicly available hospital-reported information on the quality of care delivered in the hospital outpatient setting.

(a) Hospital OQR Program Quality Measures

Hospital OQR Program payment determinations are based on the reporting of data and submission of applicable forms by hospital outpatient departments (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 OQR Program data are submitted via one of several modes: (1) chart-abstracted; (2) Medicare claims data; (3) digital; or (4) survey (Patient-Reported Outcomes-Based Performance Measures (PRO-PMs), as seen in Table 1.

[2] Pub. L. 109-432

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-based measures use information derived through Medicare fee-for-service (FFS) claims, Medicare Advantage encounter data, and beneficiary enrollment data. Because these data are already submitted by HOPDs to CMS for payment purposes, claims-based measures a do not require additional burden from HOPDs.

Digital measures include electronic clinical quality measures (eCQMs) and web-based measures. For eCQMs, information is electronically extracted from electronic health records (EHRs) and/or health information technology (HIT) systems. For "web-based" measures, measure data have been submitted differently depending on the measure. For any measures reported directly to CMS, HOPDs are required to submit measure data via CMS' Hospital Quality Reporting (HQR) system.

Survey and PRO-PM measures rely on responses to patient survey instruments. Specifically, HOPDs are required to administer the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey and submit the survey data 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) PRO-PM uses four sources of data for the calculation of the measure: (1) patient-reported (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 via survey, and responses are submitted electronically through the CMS HQR system; Medicare claims, enrollment, and beneficiary data, and U.S. Census Bureau survey data are already collected via other mechanisms and do not impose additional burden on HOPDs.

Table 1. Previously Finalized Hospital OQR Program Measures for the CY 2027 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

Measure Data Submission Mode and Name
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
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)*,**
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)
Patient-Reported Outcomes-Based Performance Measures (PRO-PMs)
Risk-Standardized PRO–PM Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO-PM)
Survey-Based Measures
Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)
Structural Measures
Hospital Commitment to Health Equity*
Process Measures
Screening for Social Drivers of Health*
Screen Positive for Social Drivers of Health*

*These measures are finalized for removal in the CY 2026 OPPS/ASC final rule.
**Burden for this measure is accounted for under OMB control number 0920-1317.

(b) Summary of Finalized Hospital OQR Program Changes

In the CY 2026 OPPS/ASC final rule, we removed five measures that impact previously approved burden estimates: (1) the HCHE measure, beginning with the CY 2025 reporting period/CY 2027 payment determination; (2) the Screening for SDOH measure, beginning with the CY 2025 reporting period; (3) the Screen Positive Rate for SDOH measure, beginning with the CY 2025 reporting period; (4) the Median Time for Discharged ED Patients measure beginning with the CY 2028 reporting period/CY 2030 payment determination; and (5) the LWBS measure beginning with the CY 2028 reporting period/CY 2030 payment determination. We also modified the Excessive Radiation eCQM from mandatory reporting, beginning with the CY 2027 reporting period/CY 2029 payment determination to continue voluntary reporting in the CY 2027 reporting period and subsequent years. Lastly, we adopted the Emergency Care Access & Timeliness eCQM, with voluntary reporting for the CY 2027 reporting period and mandatory reporting beginning with the CY 2028 reporting period/CY 2030 payment determination.

We also finalized changes to the Hospital OQR Program that will not impact previously approved burden estimates. Specifically, we removed the COVID-19 Vaccination Coverage Among HCP measure beginning with the CY 2024 reporting period/CY 2026 payment

determination. We also updated the Extraordinary Circumstances Exception (ECE) policy and codified the process for requesting or granting an ECE. This update explicitly includes *extensions* as a type of extraordinary circumstances relief option, in addition to exceptions, and changes the deadline for submitting an ECE request from 90 days to 60 days from the date of a qualifying event. Because the process for requesting or granting an ECE remains the same as the current ECE process, these updates will not affect burden associated with the submission of the ECE form.

(c) Hospital OQR 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 number 0938-1022 to reduce administrative burden and the potential for errors when updates are necessary.

The Hospital OQR Program uses five administrative forms: (1) Extraordinary Circumstances Exception (ECE) Request; (2) Reconsideration Request; (3) Validation Review; (4) Withdrawal of Participation Form; and (5) Request Form for Withholding/Footnoting Data From Public Reporting. 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 OQR Program is nominal, if any.

(1) ECE Request Form

CMS offers a process for HOPDs to request an exception to data reporting and data validation requirements when an HOPD experiences an extraordinary circumstance not within the control of the HOPD, such as a cyberattack or natural disaster. The revised 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, a finalized change from the 90-day timing used on the current form. In addition, the form indicates that for eCQM reporting under the Hospital OQR Program, the request must be submitted by June 15 following the end of a reporting period calendar year. In the CY 2026 OPPS/ASC final rule, we finalized (1) that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance; and (2) that an HOPD may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred; none of which affects collection of information burden under OMB control number 0938-1022.

(2) Reconsideration Request Form

When CMS determines that an HOPD has 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[3] on or after March 17 of the affected payment year. CMS provides this form online, and facilities may submit the form online or by fax.

(3) Validation Review Form

CMS performs a random and targeted selection of HOPDs reporting under the Hospital OQR 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 OQR 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.

(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 OQR Program, regardless of whether it continues to submit quality measure data, until it formally withdraws. To withdraw from the Hospital OQR 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.

HOPDs statutorily required to participate in the Hospital OQR 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 OQR 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

[3] 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.

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 (FSN) 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 OQR Program data to improve quality of care through education, outreach, and sharing best practices. [4]

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 OQR Program and other CMS quality programs, CMS's findings were formally written into the latest triennial National Impact Assessment Report released in 2024.[5]

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 (e.g., the automated collection of electronic patient data in EHRs for eCQMs, the free CMS Abstraction and Reporting Tool (CART) for use in collecting data from paper or electronic medical records for chart-abstracted measures, and the collection of data from federal registries like the National Healthcare Safety Network), 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 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

[4] 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.

[5] 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.

collection tool and other program requirements, and to provide education to support program participants.

To reduce burden, CMS limits the adoption of measures requiring the submission of patient-level information that must be acquired through chart-abstraction. These efforts are reflected by the collection and reporting of claims-based quality measures, quality measures collected via the HQR system, and quality measures which are digitally derived (e.g. eCQMs). The complete list of measures is organized by the type of data collected and data collection mechanism in Table 1.

For measures which collect data from claims and other administrative data in part, this section is not applicable as these measures can be or are partially calculated based on data already reported to the Medicare program for payment purposes. Therefore, no additional information technology will be required of hospitals to collect 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 OQR Program. We define a "small HOPD" as one with 1-99 beds. Approximately 1,533 small HOPDs participated in the Hospital OQR Program for the CY 2026 payment determination.

The Health Resources and Services Administration (HRSA)'s Medicare Rural Hospital Flexibility Program (Flex) 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 OQR 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 that are reliable estimates of HOPD performance. Under the Hospital OQR Program, HOPDs are required to submit CMS web-, PRO-PM, claims- and digital-based measure data on an annual basis relevant to their reporting period to make payment determinations. Frequency of data collection may vary (monthly, quarterly, annually, etc.) based on how a quality measure is specified. The following table (Table 2) details the frequency of data submission to CMS by measure type for the Hospital OQR Program.

Table 2. Frequency of Data Submission Under the Hospital OQR 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 are calculated from Medicare FFS claims data and MA encounter data; HOPDs submit claims for reimbursement 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 for this data collection was published on July 17, 2025 (90 FR 33476). Comments received regarding the burden estimates are included in this PRA package. The CY 2026 OPPS/ASC final rule was published on November 25, 2025 (90 FR 53448).

Measures adopted for the Hospital OQR Program are required by statute to undergo a recognized consensus process. Section 1890A of the Act requires CMS to consider input on the selection of quality and efficiency measures from a multi-stakeholder group convened by the "consensus-based entity." To fulfill this requirement, the Partnership for Quality Measurement provides input on the Measures under Consideration (MUC) list as part of the Pre-Rulemaking Measure Review (PRMR). We refer readers to https://p4qm.org/PRMR/About for more information on the PRMR process.

CMS is additionally supported in this program's efforts by The Joint Commission, Centers for Disease Control and Prevention, HRSA, and the Agency for Healthcare Research and Quality. These organizations consult with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making collected information

accessible, understandable, and relevant to the public. CMS also regularly engages interested parties through the solicitation of comments in rulemaking.

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. All information collected under the Hospital OQR Program will be maintained in strict accordance with statutes and regulations governing confidentiality requirements for CMS data, including the Privacy Act of 1974 (5 U.S.C. 552a), the Health Insurance Portability and Accountability Act (HIPAA), and the Quality Improvement Organizations confidentiality requirements, which can be found at 42 C.F.R. Part 480. In addition, the tools used for transmission of data are considered confidential forms of communication, and there are safeguards in place in accordance with HIPAA Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. Only HOPD-specific data will be made publicly available as mandated by statute. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted.

Data related to the Hospital OQR Program is housed in the HQR application group. CMS' HQR is a General Support System (GSS) housing protected health information (PHI). Users who access CMS' HQR system are identity-managed to permit access to the system and have role-based restrictions (including log-in and password) to the data they can see. The System of Records Notice (SORN) in use for quality programs, including the Hospital OQR 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 2026 OPPS/ASC final rule, we removed five measures that impact previously approved burden estimates: (1) the HCHE measure, beginning with the CY 2025 reporting period/CY 2027 payment determination; (2) the Screening for SDOH measure, beginning with the CY 2025 reporting period; (3) the Screen Positive Rate for SDOH measure, beginning with the CY 2025 reporting period; (4) the Median Time for Discharged ED Patients measure beginning with the CY 2028 reporting period/CY 2030 payment determination; and (5) the LWBS measure beginning with the CY 2028 reporting period/CY 2030 payment determination. We also modified the Excessive Radiation eCQM from mandatory reporting beginning with the CY 2027 reporting period/CY 2029 payment determination to continue voluntary reporting in the CY 2027 reporting period and subsequent years. Lastly, we adopted the Emergency Care Access & Timeliness eCQM, with voluntary reporting for the CY 2027 reporting period and mandatory reporting beginning with the CY 2028 reporting period/CY 2030 payment determination.

We discuss other program updates finalized in the CY 2026 OPPS/ASC final rule which will not affect information collection burden under OMB control number 0938-1109 in section B.1.a.

(b) Burden for the CY 2026 Payment Determination

Our currently approved burden estimates assumed that approximately 3,200 HOPDs will report data to the Hospital OQR Program. Based on the most recent available data from the CY 2025 Hospital OQR Program payment determination, we are maintaining that assumption. For purposes of burden estimation, we assume all activities associated with the Hospital OQR 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 OQR Program.

OMB has currently approved 4,854,112 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, we estimate a revised baseline burden of 1,988,211 hours at a cost of $58,401,195 for the CY 2027 payment determination. As previously stated, our burden estimates exclude burden associated with the COVID-19 Vaccination Coverage Among HCP measure under OMB control number 0920-1317 (expiration date January 31, 2028), 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 OQR Program Measure Set and Other Activities for the CY 2027 Payment Determination

Measure Set	*Estimated*	*Number*	*Number*	*Average*	*Annual*	*Total*

	time per record (minutes) - CY 2027 payment determination	*reporting quarters per year - CY 2027 payment determination*	*of respondents*	*number records per HOPD per quarter*	*burden (hours) per HOPD*	*Burden Hours for CY 2027 payment determination*
Administrative Activities	2,520	1	3,200	1	42	**134,400**
Chart-Abstracted Measures						
Median Time from ED Arrival to ED Departure for Discharged ED Patients	2.92	1	3,200	289	14.2	45,440
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	3,200	289	14.2	45,440
Chart-Abstracted Measure Subtotal						**90,880**
Web-Based Measures						
Patient Left Without Being Seen	10	1	3,200	1	0.167	533
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	3,200	1	0.167	533
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Chart Abstraction)	2.92	1	3,200	96	4.7	15,053
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Reporting)	10	1	640	1	0.167	107
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Chart Abstraction)	2.92	1	640	96	4.7	3,010
Hospital Commitment to Health Equity	10	1	3,200	1	0.167	533
Screening for Social Drivers of Health (Survey)	2	1	51,581,411	1	0.033	1,719,380
Screening for Social Drivers of Health (Reporting)	10	1	1,600	1	0.167	267
Screen Positive for Social Drivers of Health	10	1	1,600	1	0.167	267

Web-Based Measures Subtotal						**1,739,683**
eCQM Measures						
STEMI	10	2	3,200	1	0.33	1,067
Excessive Radiation eCQM (Voluntary)	10	1	640	1	0.167	107
Login and Run Software for Excessive Radiation eCQM (Voluntary)	15	1	640	1	0.25	160
eCQM Measures Subtotal						**1,334**
PRO-PM						
THA/TKA (Voluntary Patient Surveys)	7.25	2	131,698	1	0.12083	15,914
Information Transfer (Voluntary Patient Surveys)*						
Information Transfer (Voluntary Reporting)*						
PRO-PM Subtotal						**15,914**
Validation	15	1	500	48	12	**6,000**
Total Burden Hours						**1,988,211**
Total Burden @ Average Individual Labor rate ($25.63/hr)						**$44,475,585**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$13,925,610**

*These measures do not begin voluntary reporting until the CY 2026 reporting period.

Changes to currently approved burden estimates due to measure adoptions in the CY 2026 OPPS/ASC final rule are discussed below.

(a) Updated Hourly Wage Rate

The most recent data from the Bureau of Labor Statistics May 2024 National Occupational Employment and Wage Estimates reflects a median hourly wage of $27.53 per hour for medical records specialists working in "general medical and surgical hospitals"[6] 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 $55.06 per hour throughout the discussion in this section of this rule for the Hospital OQR Program.

(b) Administrative Burden

[6] U.S. Bureau of Labor Statistics. Occupational Outlook Handbook, Medical Records Specialists. Accessed April 8, 2025. Available at: https://data.bls.gov/oes/#/industry/622100.

Administrative burden involves the time and effort associated with maintaining familiarity with Hospital OQR 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 OQR 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 OQR Program utilizes five forms in its administrative activities: (1) Extraordinary Circumstances Exception (ECE) Request; (2) Reconsideration Request; (3) Validation Review; and (4) Withdrawal from Participation Form; and (5) Request Form for Withholding/Footnoting Data From Public Reporting. 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 associated with forms utilized in the Hospital OQR Program is nominal, if any.

The burden associated with submitting an ECE Request is accounted for in OMB control number 0938-1022 (expiration date January 31, 2026) and is therefore excluded from this burden estimate. Moreover, consistent with regulations under the Paperwork Reduction Act of 1995, 5 C.F.R. § 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.

In the CY 2026 OPPS/ASC final rule, we did not finalize 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 134,400 hours (42 hours per HOPD x 3,200 HOPDs) at a cost of $7,400,064 (134,400 hours x $55.06 per hour).

(c) Chart-Abstraction Burden

For the CY 2026 reporting period/CY 2028 payment determination, the chart-abstracted measure set for the Hospital OQR 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 has been finalized to become mandatory.

For chart-abstracted measures where patient-level data are submitted directly to CMS, we previously estimated 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 are reported per HOPD for chart-abstracted measures. We therefore estimate that it will require approximately 14.2 hours (0.049 hours x 289 cases) at a cost of approximately $782 per HOPD (14.2 hours x $55.06) to collect and report data for each chart-abstracted measure. Therefore, for all participating HOPDs, we estimate an annual chart-abstraction burden of 45,440 hours (14.2 hours per HOPD x 3,200 HOPDs) at a cost of $2,501,926 per measure (45,440 hours x $55.06). For the CY 2028 and 2029 payment determinations, the total annual burden for all HOPDs to submit both measures are estimated to be 90,880 hours (45,440 hours/measure x 2 measures) at a cost $5,003,853 (90,880 hours x $55.06). 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 45,440 hours at a cost of $2,501,926.

Table 4. Estimated Burden for the Chart-Abstracted Measure Reporting and Submission Requirements for the CY 2028 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 2028 and CY 2029 Payment Determinations						
Median Time from ED Arrival to ED Departure for Discharged ED Patients measure	2.92	1	3,200	289	14.2	45,440
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	3,200	289	14.2	45,440
Total Burden Hours						**90,880**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$5,003,853**
CY 2030 Payment Determination and subsequent years						
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who	2.92	1	3,200	289	14.2	45,440

Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival measure						
Total Burden Hours						**45,440**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$2,501,926**

(d) Web-Based Measures Burden

In the CY 2026 OPPS/ASC final rule, we removed the HCHE, the Screening for SDOH, and the Screen Positive for SDOH measures beginning with the CY 2025 reporting period. As a result, we do not include any burden associated with these measures in this information collection request under OMB control number 0938-1109.

There are four web-based measures in the Hospital OQR Program for the CY 2026 reporting period/CY 2028 payment determination and subsequent years: (1) LWBS, (2) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients, (3) Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, and (4) COVID-19 Vaccination Coverage Among HCP. The Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure is voluntary; we estimate that approximately 20 percent of hospitals 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 has been finalized to become mandatory, and the COVID–19 Vaccination Coverage Among HCP measure beginning with the CY 2024 reporting period/CY 2026 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 2028 and 2029 payment determination, we estimate a total annual burden for all HOPDs of 1,173 hours [(0.167 hours/HOPD x 3,200 HOPDs x 2 measures) + (0.167 hours/hospital x 3,200 hospitals x 20 percent x 1 measure)] at a cost of $64,585 (1,173 hours x $55.06) for all three measures. For the CY 2030 payment determination and subsequent years, we estimate a total annual burden for all HOPDs of 640 hours [(0.167 hours/HOPD x 3,200 HOPDs x 1 measure) + (0.167 hours/hospital x 3,200 hospitals x 20 percent x 1 measure)] at a cost of $35,238 (640 hours x $55.06) for both measures.

There are two web-based measures in the Hospital OQR 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 OQR 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.[7] To be conservative, we base our burden estimates on an estimate of 96 cases per HOPD annually. For the CY 2028 payment determination and subsequent years, we estimate a chart-abstraction burden of 18,063 hours [(0.049 hours/case x 96 cases/measure x 3,200 HOPDs x 1 measure) + (0.049 hours/case x 96 cases/measure x 3,200 HOPDs x 20 percent x 1 measure)] at a cost of $994,549 (18,063 hours x $55.06) for both measures.

Table 5. Estimated Burden for the Web-Based Measure Reporting and Submission Requirements for the CY 2028 through CY 2030 Payment Determination Years

Web-Based Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of Respondents***	***Average number records per Respondent per quarter***	***Annual burden (hours) per Respondent***	***Total Annual hours for all Respondents***
CY 2028 and CY 2029 Payment Determinations						
Left Without Being Seen	10	1	3,200	1	0.167	533
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	3,200	1	0.167	533
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Chart Abstraction)	2.9	1	3,200	96	4.7	15,053
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Reporting)	10	1	640	1	0.167	107
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Chart Abstraction)	2.9	1	640	96	4.7	3,010
Total Burden Hours						**19,236**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$1,059,134**

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

CY 2030 Payment Determination and subsequent years						
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	3,200	1	0.167	533
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Chart Abstraction)	2.9	1	3,200	96	4.7	15,053
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Reporting)	10	1	640	1	0.167	107
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Chart Abstraction)	2.9	1	640	96	4.7	3,010
Total Burden Hours						**18,703**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$1,029,787**

(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 OQR 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 two eCQMs in the Hospital OQR Program for the CY 2026 reporting period/CY 2028 payment determination and subsequent years: the Appropriate Treatment for ST-Segment Elevation Myocardial Infarction Patients in the Emergency Department (STEMI eCQM) and the Excessive Radiation eCQM. 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. We also modified the Excessive Radiation eCQM from mandatory reporting beginning with the CY 2027 reporting period/CY 2029 payment determination, to continue voluntary in the CY 2027 reporting period and subsequent years.

For the CY 2026 reporting period/CY 2028 payment determination, HOPDs are required to report the STEMI eCQM for three self-selected quarters followed by four quarters for the CY 2027 reporting period/CY 2029 payment determination and for subsequent years. 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 2026 reporting period/CY 2028 payment determination, we estimate the annual burden for all HOPDs to be 1,600 hours (3,200 HOPDs x 0.167 hours x 3 quarters) at a cost of $88,096 (1,600 hours x $55.06). For the CY 2027 reporting period/CY 2029 payment determination and subsequent years, we estimate the annual burden for all HOPDs to be 2,133 hours (3,200 HOPDs x 0.167 hours x 4 quarters) at a cost of $117,443 (2,133 hours x $55.06).

For the Excessive Radiation eCQM, in the CY 2024 OPPS/ASC final rule we finalized voluntary reporting for the CY 2026 reporting period, then gradually increasing the number of quarters of data HOPDs will be required to report on the measure starting with two self-selected quarters for the CY 2027 reporting period/CY 2029 payment determination, and all four quarters for the CY 2028 reporting period/CY 2030 payment determination. In the CY 2026 OPPS/ASC final rule, we modified the Excessive Radiation eCQM to continue voluntary reporting beginning with the CY 2027 reporting period. 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 2026 reporting period and subsequent years, we estimate an annual burden for voluntarily participating HOPDs of 107 hours (3,200 HOPDs × 20 percent × 0.167 hours × 1 quarter) at a cost of $5,891 (107 hours × $55.06).

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 HOPD will spend approximately 15 minutes (0.25 hours) annually to conduct these activities prior to data submission. We estimate an annual burden of 160 hours (0.25 hours x 3,200 HOPDs × 20 percent) at a cost of $8,810 (160 hours x $55.06).

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 OQR 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 x 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 estimation purposes, we estimate 20 percent of HOPDs will voluntarily report one quarter of data for the measure in the CY 2027 reporting period, with 100 percent of HOPDs reporting the measure as required in subsequent years. For voluntary reporting for the CY 2027 reporting period, we estimate an annual burden for voluntarily participating HOPDs of 107 hours (3,200 HOPDs × 20 percent × 0.167 hours × 1 quarter) at a cost of $5,891 (107 hours × $55.06). Beginning with the CY 2028 reporting period, we estimate the annual burden for all participating HOPDs to be 2,133 hours (0.67 hours x 3,200 HOPDs) at a cost of $117,443 (2,133 hours x $55.06).

Based on the calculations discussed in this section, we estimate a total burden for reporting eCQMs for the CY 2026 reporting period/CY 2028 payment determination of 1,867 hours (1,067 + 107 + 160) at a cost of $102,797 ($88,096 + $5,891 + $8,810). For the CY 2027 reporting period/FY 2029 payment determination, we estimate a total burden of 2,507 hours (2,133 + 107 + 160 + 107) at a cost of $138,035 ($117,443 + 5,891 + $8,810 + $5,891). For the CY 2028 reporting period/FY 2030 payment determination and subsequent years, we estimate a total annual burden of 4,533 hours (2,133 + 107 + 160 + 2,133) at a cost of $249,587 ($117,443 + $5,891 + $8,810 + $117,443).

Table 6. Estimated Burden for the eCQM Reporting and Submission Requirements for the CY 2028 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 2028 Payment Determination						
STEMI eCQM	10	3	3,200	1	0.50	1,600
Excessive Radiation eCQM (Voluntary)	10	1	640	1	0.167	107
Login and Run Software for Excessive Radiation eCQM (Voluntary)	15	1	640	1	0.25	160
Total Burden Hours						**1,867**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$102,797**
CY 2029 Payment Determination						
STEMI eCQM	10	4	3,200	1	0.67	2,133
Excessive Radiation eCQM (Voluntary)	10	1	640	1	0.167	107
Login and Run Software for Excessive Radiation	15	1	640	1	0.25	160

eCQM (Voluntary)						
Emergency Care Access &Timeliness eCQM (Voluntary)	10	1	640	1	0.167	107
Total Burden Hours						**2,507**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$138,035**
CY 2030 Payment Determination and Subsequent Years						
STEMI eCQM	10	4	3,200	1	0.67	2,133
Excessive Radiation eCQM (Voluntary)	10	1	640	1	0.167	107
Login and Run Software for Excessive Radiation eCQM (Voluntary)	15	1	640	1	0.25	160
Emergency Care Access & Timeliness eCQM (Mandatory)	10	4	3,200	1	0.67	2,133
Total Burden Hours						**4,533**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$249,587**

(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 believe the estimated burden for both patient surveys and data submission will be the same for the Hospital OQR Program.

The THA/TKA PRO–PM uses four sources of data for the calculation of the measure: (1) PRO data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. We estimate no additional burden associated with claims data, Medicare enrollment and beneficiary data, and U.S. Census Bureau survey data as these data are already collected via other mechanisms 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 will begin with CY 2026 for eligible procedures occurring between January 1, 2026, through December 31, 2026; and the third voluntary reporting period will begin 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 $25.63/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.[8] To derive the costs for patients (or their representatives), a measurement of the usual weekly earnings of wage and salary workers of $1,192 is divided by 40 hours to calculate an hourly pre-tax wage rate of $29.80/hr.[9] This rate is adjusted downwards by an estimate of the effective tax rate for median income

[8] 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.

[9] Bureau of Labor and Statistics, Usual Weekly Earnings of Wage and Salary Workers, First Quarter 2024. Available at https://www.bls.gov/news.release/pdf/wkyeng.pdf. Accessed April 16, 2024

households of about 14 percent calculated by comparing pre- and post-tax income, [10] resulting in the post-tax hourly wage rate of $25.63/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 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 CYs 2026 and 2027 reporting periods, 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 $407,876 (15,914 hours × $25.63). 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 $1,631,452 (63,654 hours × $25.63) 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 occurring in CY 2025, pre-operative survey data submission will occur in the first quarter of the CY 2026 reporting period and post-operative survey data submission will occur in the first quarter of the CY 2027 reporting period. For each 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 2026 reporting period, we estimate a burden for 50 percent of voluntarily participating HOPDs of 267 hours (0.167 hours × 3,200 HOPDs × 50 percent) at a cost of $14,701 (267 hours × $55.06). For the CY 2027 and CY 2028 reporting periods, we estimate a burden for 50 percent of voluntarily participating HOPDs of 533 hours (0.33 hours × 3,200 HOPDs × 50 percent) at a cost of $29,347 (533 hours × $55.06). 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 800 hours [(0.167 hours × 3,200 HOPDs × 50 percent) + (0.167 hours x 3,200 HOPDs)] at a cost of $44,048 (800 hours × $55.06). For mandatory reporting for the CY 2030 reporting period and subsequent years, we estimate a total of 1,067 hours (0.33 hours × 3,200 HOPDs) at a cost of $58,749 (1,067 hours × $55.06).
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), Patient Reported Outcome-Based Performance Measure (PRO-PM) beginning with voluntary reporting for the CY 2026 reporting period and mandatory reporting beginning with

[10] U.S. Census Bureau, End of Pandemic-Era Expanded Federal Tax Programs Results in Lower Income, Higher Poverty, September 12, 2023. Available at https://www.census.gov/library/stories/2023/09/median-household-income.html. Accessed April 16, 2024

the CY 2027 reporting period/CY 2029 payment determination. The Information Transfer PRO–PM will use 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 825,109,281 hospital outpatient visits ((2,426 outpatient visits per 1,000 population in CY 2023[11]) × 340,110,998 total U.S population[12]). We then estimate a total of 425,838,899 HOPD patient visits potentially resulting in a patient needing to be screened when the measure becomes mandatory by multiplying the total 825,109,281 hospital outpatient visits by a ratio of 3,200 HOPDs to the total of 6,200 hospitals surveyed[13] (825,109,281 hospital outpatient visits x 51.61 percent (3,200 HOPDs ÷ 6,200 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 141,946,300 hospital outpatient visits (425,838,899 hospital outpatient visits ÷ 3 surgery or procedure-specific visits) would more realistically qualify for the cohort of this measure. As submission rates among facilities may vary, we conservatively estimate that for voluntary reporting for the CY 2026 reporting period, 50 percent of HOPDs will survey 50 percent of patients, and beginning with the first mandatory reporting period, 100 percent of HOPDs will survey 100 percent of patients. 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.[14] For voluntary reporting for the CY 2026 reporting period, we estimate a total burden for patients of 2,957,215 hours (141,946,300 patients × 50 percent response rate × 50 percent of HOPDs × 0.083 hours per patient surveyed) at a cost of $75,793,420 (2,957,215 hours × $25.63/hour). Beginning with mandatory reporting for the CY 2027 reporting period and subsequent years, we estimate an annual total burden for patients of 11,828,858 hours (141,946,300 patients × 0.083 hours per patient) at a cost of $303,173,631 (11,828,858 hours × $25.63).

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

[11] 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

[12] United States Census Bureau – Quickfacts. Available at https://www.census.gov/quickfacts/fact/table/US/PST045224. Accessed June 4, 2025.

[13] American Hospital Association – Data and Insights, AHA Annual Survey Database™. Available at https://www.ahadata.com/aha-annual-survey-database.

[14] 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.

OQR Program, we estimate a burden of 10 minutes (0.167 hours) per HOPD to report measure data. For voluntary reporting for the CY 2026 reporting period, we estimate a total collection and reporting burden for program-eligible HOPDs of 267 hours (3,200 HOPDs × 50 percent of HOPDs × 0.167 hours per HOPDs) at a cost of $14,701 (267 hours × $55.06/hour). Beginning with mandatory reporting for the CY 2027 reporting period and subsequent years, we estimate a total collection and reporting burden for program-eligible HOPDs of 533 hours (3,200 HOPDs × 0.167 hours per HOPD) at a cost of $29,347 (533 hours × $55.06).

Table 7. Estimated Burden for the PRO-PM Reporting and Submission Requirements for the CY 2028 through CY 2032 Payment Determination Years

PRO-PM Measure Reporting	***Estimated time per record (minutes)***	***Number reporting quarters per year***	***Number of Respondents***	***Average number records per Respondent per quarter***	***Annual burden (hours) per Respondent***	***Total Annual hours for all Respondents***
CY 2028 Payment Determination						
THA/TKA (Voluntary Patient Surveys)	7.25	2	131,698	1	0.12083	15,914
THA/TKA (Voluntary Measure Reporting)	10	1	1,600	1	0.167	267
Information Transfer (Voluntary Patient Surveys)	5	1	35,486,575	1	0.083	2,957,215
Information Transfer (Voluntary Reporting)	10	1	1,600	1	0.167	267
Total Burden Hours						**2,973,663**
Total Burden @ Individual labor rate ($25.63/hr)						**$76,201,296**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$29,402**
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	1	1,600	1	0.167	533
Information Transfer (Mandatory Patient Surveys)	5	1	141,946,300	1	0.083	11,828,858
Information Transfer (Mandatory Reporting)	10	1	3,200	1	0.167	533
Total Burden Hours						**11,845,838**
Total Burden @ Individual labor rate ($25.63/hr)						**$303,581,506**

Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$58,694**
CY 2030 Payment Determination						
THA/TKA (Mandatory Patient Surveys)	7.25	2	131,698	1	0.12083	63,654
THA/TKA (Voluntary Measure Reporting)	10	2	1,600	1	0.33	533
Information Transfer (Mandatory Patient Surveys)	5	1	141,946,300	1	0.083	11,828,858
Information Transfer (Mandatory Reporting)	10	1	3,200	1	0.167	533
Total Burden Hours						**11,893,578**
Total Burden @ Individual labor rate ($25.63/hr)						**$304,805,083**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$58,694**
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	1,600	1	0.167	267
THA/TKA (Mandatory Measure Reporting)	10	1	3,200	1	0.167	533
Information Transfer (Mandatory Patient Surveys)	5	1	141,946,300	1	0.083	11,828,858
Information Transfer (Mandatory Reporting)	10	1	3,200	1	0.167	533
Total Burden Hours						**11,893,845**
Total Burden @ Individual labor rate ($25.63/hr)						**$304,805,083**
Total Burden @ Medical Records Specialist labor rate ($55.06/hr)						**$73,395**
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	3,200	1	0.167	1,067
Information Transfer (Mandatory Patient Surveys)	5	1	141,946,300	1	0.083	11,828,858
Information Transfer (Mandatory Reporting)	10	1	3,200	1	0.167	533
Total Burden Hours						**11,894,112**
Total Burden @ Individual labor rate ($25.63/hr)						**$304,805,083**

Total Burden @ Medical Records Specialist labor rate ($55.06/hr)	**$88,096**

(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 12 hours 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).

Because all selected HOPDs must comply with these requirements each year, we continue to estimate a total submission of up to 24,000 charts by the selected HOPDs (500 HOPDs × 48 cases per HOPD) (76 FR 74553). Therefore, for the selected HOPDs, we continue to estimate a total annual validation burden, for four quarters of data, of 6,000 hours (500 HOPDs x 12 hours per hospital), and a total financial burden of approximately $330,360 (6,000 hours x $55.06).

HOPDs with less than four quarters of data subject to validation due to receiving an ECE for one or more quarters, and with a two-tailed confidence interval that is less than 75 percent, will be targeted for validation in the subsequent validation year. However, these HOPDs will not be penalized for payment. HOPDs will still be subject to both payment penalty and targeting for validation in the subsequent validation year if they either (a) have less than four quarters of data but do not have an ECE or waiver for one or more quarters and do not meet the 75 percent threshold; or (b) have four quarters of data subject to validation and do not meet the 75 percent threshold. This policy does not increase reporting burden, because it changes neither the total number of HOPDs required to submit data nor the amount of data HOPDs selected for validation will be required to submit.

(j) Total Burden for the CY 2028 through CY 2031 Payment Determinations

As shown in Tables 8 and 9, in summary, under OMB control number 0938-1109, we estimate a total annual information collection burden of 3,226,046 hours at a cost of $90,126,906 for the CY 2026 reporting period/CY 2028 payment determination. We also estimate an annual decrease of 6,559,308 hours and $169,530,772 for 3,200 HOPDs associated with our finalized measure removals, adoptions, and modifications as well as updated burden estimates described above related to this information collection of (which also reflects use of updated hourly wage rates as previously discussed), from the CY 2026 reporting period/CY 2028 payment determination through the CY 2029 reporting period/CY 2031 payment determination, compared to our currently approved information collection burden estimates. The tables below summarize the total burden changes for each respective CY payment determination compared to our currently approved information collection burden estimates (the columns in each table for the CY 2031 payment determination reflects the cumulative burden changes).

Table 8. Total Burden Hours for the CY 2028 through CY 2031 Payment Determinations

Information Collection	CY 2028	Difference from Currently Approved	CY 2029	Difference from Currently Approved	CY 2030	Difference from Currently Approved	CY 2031	Difference from Currently Approved
Administrative Activities	134,400	0	134,400	0	134,400	0	134,400	0
Chart-Abstracted Measures	90,880	0	90,880	0	45,440	-45,440	45,440	-45,440
Web-Based Measures	19,236	-6,879,123	19,236	-6,879,123	18,703	-6,879,656	18,703	-6,879,656
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	1,867	0	2,507	-1,493	4,533	-534	4,533	-534
PRO-PM	2,973,663	-8,505,587	11,845,838	366,322	11,893,578	366,322	11,893,845	366,322
Validation	6,000	0	6,000	0	6,000	0	6,000	0
TOTAL	**3,226,046**	**-15,384,710**	**12,098,861**	**-6,514,295**	**12,102,654**	**-6,559,309**	**12,102,921**	**-6,559,308**

Table 9. Total Burden Dollars for the CY 2028 through CY 2031 Payment Determinations*

Information Collection	CY 2028	Difference from Currently Approved	CY 2029	Difference from Currently Approved	CY 2030	Difference from Currently Approved	CY 2031	Difference from Currently Approved
Administrative Activities	$7,400,064	$0	$7,400,064	$0	$7,400,064	$0	$7,400,064	$0
Chart-Abstracted Measures	$5,003,853	$0	$5,003,853	$0	$2,501,926	($2,501,926)	$2,501,926	($2,501,926)
Web-Based Measures	$1,059,134	($176,358,930)	$1,059,134	($176,358,930)	$1,029,787	($176,388,277)	$1,029,787	($176,388,277)
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	$102,797	$0	$138,035	($82,205)	$249,587	($29,402)	$249,587	($29,402)
PRO-PM	$76,230,698	$218,006,023	$303,640,200	$9,388,833	$304,863,777	$9,388,833	$304,878,478	$9,388,833
Validation	$330,360	$0	$330,360	$0	$330,360	$0	$330,360	$0
TOTAL	**$90,126,906**	**($394,364,953)**	**$317,571,647**	**($167,052,302)**	**$316,375,501**	**($169,530,772)**	**$316,390,202**	**($169,530,772)**

* 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.

While we do not expect HOPDs will experience an increase in information collection burden associated with the policy to require EHR technology to be certified to all eCQMs available to report, we expect some costs related to certifying new eCQMs for HOPDs so that the eCQM is available for HOPDs to report. However, due to the differences in the build of respective CEHRT deployed in HOPDs, the mapping required to capture required data for measure calculation, and the range of HOPD participation in the development, implementation, and testing of new CEHRT functionality, an estimated cost impact of the policy is not quantifiable as it will vary by CEHRT and HOPD.

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 $136,658 plus benefits (30 percent) of $40,997 for a total cost of $177,655. The total annual cost to the Federal Government is $10,227,655.

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 2026 reporting period/CY 2028 payment determination of 18,610,756 hours at a cost of $463,647,584 as a result of policies finalized in the CY 2025 OPPS/ASC final rule. Accounting for updated wage rates, the total cost of $463,647,584 increases to $484,491,859. For the CY 2026 reporting period/CY 2028 payment determination, based on the measure removals and adoptions in the CY 2026 OPPS/ASC final rule, we estimate a total burden of 3,226,046 hours at a cost of $90,126,906 (a decrease of 15,384,710 hours and $394,364,953 from our previous request). This burden estimate also represents a decrease of 11,958,951 hours from the currently

approved burden estimate of 15,184,997 hours CY 2025 reporting period/CY 2027 payment determination.

The removal of the HCHE measure will result in a total estimated burden decrease of 533 hours at a cost of $29,347 beginning with the CY 2027 payment determination. The removals of the Screening for SDOH and Screen Positive Rate for SDOH measures will result in a total estimated burden decrease of 6,878,058 hours at a cost of $176,300,291 and 533 hours at a cost of $29,347, respectively, beginning with the CY 2025 reporting period. The finalized change from mandatory to voluntary reporting for the Excessive Radiation eCQM will result in a total estimated burden decrease of 2,666 hours at a savings of $146,790 beginning with the CY 2030 payment determination. The adoption of the Emergency Care Access & Timeliness eCQM will result in a total estimated burden increase of 2,133 hours at a cost of $117,443 when mandatory reporting begins for the CY 2028 payment determination. The removal of the Median Time for Discharged ED Patients measure will result in a total estimated burden decrease of 45,440 hours at a savings of $2,501,926 when mandatory reporting for the Emergency Care Access & Timeliness eCQM begins for the CY 2030 payment determination. The removal of the LWBS measure will result in a total estimated burden decrease of 533 hours at a savings of $29,347 when mandatory reporting for the Emergency Care Access & Timeliness eCQM begins for the CY 2030 payment determination. Lastly, adjustments to the number of patients surveyed for the Information Transfer PRO-PM based on more recent data result in an increase of 366,322 hours at a cost of $9,388,833.

The aggregate decrease due to these measure removals, adoptions, and modifications as reflected in our burden estimates for the CY 2031 payment determination is 6,559,308 hours (-533 – 6,878,058 – 533 – 2,666 + 2,133 – 45,440 – 533 + 366,322) and $169,530,772 (-$29,347 - $176,300,291 - $29,347 - $146,790 + $117,443 - $2,501,926 - $29,347 + $9,388,833) as shown in Tables 8 and 9 (minor differences due to rounding).

16. Publication

As required by authorizing statute, quality measure data are made publicly available after providing HOPDs the opportunity to review their data. The goal of the data collection is to tabulate and publish HOPD-specific data. Hospital data from these initiatives are currently used to populate the Compare tool and CMS' Provider Data Catalog. 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 public display may be delayed 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 OQR 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.