

Supporting Statement – Part A

Collection of Information for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program: CY 2026 OPPS/ASC Proposed Rule (OMB# 0938-1270; CMS-10530)

A. Background

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

Specifically, CMS has implemented quality reporting programs for multiple settings, including for ambulatory surgical centers (ASCs), as authorized by statute, and seeks to achieve overarching priorities and initiatives promoting quality healthcare, such as detailed in the Meaningful Measures 2.0 Framework.¹ The Meaningful Measures 2.0 Framework 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 for the ASCQR Program are approved under OMB control number 0938-1270 (expiration date January 31, 2026). This revised information collection request covers data collection requirements for CYs 2028 through 2031 payment determinations and subsequent years. This revised information collection request includes burden associated with the proposed removal of the Facility Commitment to Health Equity (FCHE), Screening for Social Drivers of Health (SDOH), and Screen Positive Rate for SDOH measures, as well as the proposed adoption of Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance measure (Information Transfer PRO-PM).

B. Justification

1. Need and Legal Basis

The Ambulatory Surgical Center Quality Reporting (ASCQR) Program was established under section 1833(t) of the Social Security Act (the Act). A quality reporting program for ASCs was authorized by section 109(b) of the Medicare Improvements and Extension Act of the Tax Relief and Health Care Act of 2006² which amended section 1833(i) of the Act. Section

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

² Pub. L. 109-432

1833(i)(2)(D)(iv) of the Act states that the Secretary may provide that any Ambulatory Surgical Center (ASC) that does not submit quality measures to the Secretary in accordance with paragraph (7) may incur a 2.0 percentage point reduction to any annual increase provided under the revised ASC payment system for such year.

Section 1833(i)(7)(B) of the Act provides that, “[e]xcept as the Secretary may otherwise provide,” the hospital outpatient quality data provisions of subparagraphs (B) through (E) of section 1833(t)(17) of the Act shall apply to ASCs in a similar manner to the manner in which they apply under these paragraphs to hospitals and any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ASC, the setting of an ASC, or services of an ASC, respectively. Section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form, manner, and at a time that the Secretary specifies.

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

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

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

(a) ASCQR Program Measures

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

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

For “web-based” measures, measure data are submitted via one of two web-based tools, depending on the measure. For any structural and process measures reported directly to CMS, ASCs are required to submit measure data via CMS’ Hospital Quality Reporting (HQR) system.

The COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure is calculated using data submitted via the Centers for Disease Control and Prevention’s (CDC) National Healthcare Safety Network (NHSN) under OMB control number 0920-1317 (expiration date January 31, 2028).

Lastly, the ASCQR Program includes survey and PRO-PM measures, which utilize information derived through analysis of responses to a survey instrument. ASCs 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, which expires November 30, 2026. The Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM) uses the following sources of data for measure calculation: (1) patient-reported (PRO) data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. ASCs collect the PRO data via survey, and responses are submitted electronically via the CMS HQR system; claims data, Medicare enrollment and beneficiary data are already collected via other mechanisms.

Table 1. ASCQR Program Measures for the CY 2027 Payment Determination and Subsequent Years

Measure Submission Mode and Name
Web-Based Measures
Patient Burn
Patient Fall
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
All-Cause Hospital Transfer/Admission
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery
Normothermia Outcome
Unplanned Anterior Vitrectomy
COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)*. **
Survey-Based Measures
Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)***
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 Ambulatory Surgical Center (ASC) Setting (THA/TKA PRO-PM)
Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance measure (Information Transfer PRO-PM)****
Claims-Based Measures
Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy

Measure Submission Mode and Name
Hospital Visits After Orthopedic ASC Procedures
Hospital Visits After Urology ASC Procedures
Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at ASCs
Structural Measures
Facility Commitment to Health Equity**
Process Measures
Screening for Social Drivers of Health**
Screen Positive for Social Drivers of Health**

*Burden for this measure is accounted for under OMB control number 0920-1317.

**These measures are proposed for removal in the CY 2026 OPPS/ASC proposed rule.

***Burden for these measures is accounted for under OMB control number 0938-1240.

****This measure is proposed in the CY 2026 OPPS/ASC proposed rule to begin with voluntary reporting for the CY 2027 and CY 2028 reporting periods followed by mandatory reporting to begin with the CY 2029 reporting period /CY 2031 payment determination.

(b) Summary of Proposed ASCQR Program Changes

In the CY 2026 OPPS/ASC proposed rule, we proposed to remove three measures that would impact previously approved burden estimates: (1) the FCHE measure, beginning with the CY 2025 reporting period/CY 2027 payment determination; (2) the Screening for SDOH measure, beginning with the CY 2025 reporting period; and (3) the Screen Positive Rate for SDOH measure, beginning with the CY 2025 reporting period. We also proposed to adopt the Information Transfer PRO-PM beginning with voluntary reporting for the CY 2027 and CY 2028 reporting periods, followed by mandatory reporting beginning with the CY 2029 reporting period/CY 2031 payment determination.

We also proposed changes to the ASCQR Program that would not impact previously approved burden estimates. Specifically, we proposed to remove the COVID-19 Vaccination Coverage Among HCP measure beginning with the CY 2024 reporting period/CY 2026 payment determination. We are also proposing to update the Extraordinary Circumstances Exception (ECE) policy and codify the process for requesting or granting an ECE. This proposed update would explicitly include *extensions* as a type of extraordinary circumstances relief option, in addition to exceptions. Because the process for requesting or granting an ECE would remain the same as the current ECE process, these updates would not affect burden associated with the submission of the ECE form.

(c) ASCQR 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. As a result, many of the forms are used for multiple programs and are included under OMB control number 0938-1022 to reduce administrative burden and the potential for errors when updates are necessary.

The ASCQR Program uses four administrative forms: (1) Extraordinary Circumstances Exception Request form; (2) Reconsideration Request form; (3) Withdrawal of Participation

form; and (4) Request Form for Withholding/Footnoting Data From Public Reporting. These forms are completed only on a need-to-use, exception basis and most ASCs will not need to complete any of these forms in a given year. Thus, the burden for providers associated with forms utilized in the ASCQR Program is nominal, if any.

(1) Extraordinary Circumstances Exception (ECE) Request Form

CMS offers a process for ASCs to request exceptions to data reporting requirements when an ASC experiences an extraordinary circumstance not within the control of the ASC, such as a natural disaster. The CMS Quality Program ECE Request Form under development indicates that for non-eCQMs, the request must be submitted within 30 calendar days of an extraordinary circumstance event for all programs, a proposed change from the 90-day timing used on the current form. In the CY 2026 OPPI/ASC proposed rule, we are proposing (1) that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance; and (2) that an ASC may request an ECE within 30 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 ASC has not met program requirements and is subject to a 2.0 percentage point reduction in their annual payment update (APU), the ASC may submit a Reconsideration Request to CMS no later than the first business day³ on or after March 17 of the affected payment year. CMS provides this form online and facilities may submit the form online or by fax.

(3) Withdrawal of Participation Form

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

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

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

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.

submits a new Request Form for Withholding/Footnoting Data from Public Reporting indicating the measure(s) the ASC would like to withhold from public reporting for the period.

2. Information Users

The ASCQR Program as a pay-for-reporting program strives to have a streamlined measure set that provides meaningful measurement that also serves to differentiate facilities by quality of care while limiting burden to the fullest extent possible. CMS provides confidential feedback reports that ASCs may use to assess their performance and operationalize quality improvement activities throughout the quality reporting period. These reports include the data that CMS has collected from the ASC, and some also include information about how the ASC's data compare relative to the performance of other ASCs. For example, the Facility, State and National (FSN) Report allows ASCs to compare their performance related to a specific measure during a specific timeframe, to the average performance of other ASCs at the state and national levels.

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

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

Under section 1890A(a)(6) of the Social Security Act, CMS is required to evaluate the impact and efficiency of CMS measures in quality reporting programs and to post the report every three years. Following the compilation of data from the CMS quality programs, CMS' findings were formally written into the latest triennial National Impact Assessment Report, which was released in 2024.⁴

3. Use of Information Technology

To assist ASCs in participating in standardized data collection initiatives across the industry, CMS continues to improve data collection tools with the goal of making data submission easier and to increase the utility of the data provided by the ASCs. As an example, CMS employs the established, free data collection tool, the CMS Abstraction and Reporting Tool (CART) for use in collecting data from paper or electronic medical records for chart-abstracted measures. CMS also provides a secure data warehouse via the HQR system for storage and transmittal of data as well as data validation and aggregation services prior to the release of data to the CMS website.

⁴ 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>.

ASCs 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 program requirements and to provide education to support program participants.

In an effort to reduce burden, CMS also limits the adoption of measures requiring the submission of patient-level information that must be acquired through chart-abstraction and employs existing data and data collection systems. 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 type of data collected and data collection mechanism in Table 1.

For claims-based measures, or measures which collect data from claims, and other administrative data in part, this section is not applicable, as these measures are fully calculated using data that are reported to the Medicare program for payment purposes. Therefore, no additional information technology will be required of ASCs to collect data for these measures.

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect quality of care data for ASC care. CMS requires ASCs to submit quality measure data for services provided in the ambulatory surgical setting. We prioritize efforts to reduce reporting burden for the collection of quality-of-care information by utilizing electronic data that ASCs may collect for reporting for accreditation purposes.

5. Small Business

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

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

6. Less Frequent Collection

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

on how a quality measure is specified. The following table details the frequency of data submission to CMS by measure type for the ASCQR Program.

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

Measure Type	Frequency of Data Submission
Web-based	Annually
Survey-based	Quarterly
PRO-PM	Annually

Claims-based measures are calculated from Medicare FFS claims and beneficiary data; ASCs submit claims for reimbursement per claims processing timeliness requirements. To collect these measure data less frequently could compromise the timeliness of any calculated estimates.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

A 60-day Federal Register notice for this data collection was published on July 17, 2025 (90 FR 33476).

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

CMS is additionally supported in quality reporting program efforts by The Joint Commission, CDC, Health Resources and Services Administration, and the Agency for Healthcare Research and Quality. These organizations consult with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making collected information accessible, understandable, and relevant to the public. CMS also regularly engages interested parties through the solicitation of comments in rulemaking.

9. Payment/Gift to Respondent

ASCs 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 ASCs for participation.

10. Confidentiality

To the extent provided by law, all information collected under the ASCQR Program will be maintained in strict accordance with statutes and regulations governing confidentiality requirements for CMS data, including the Privacy Act of 1974 (5 U.S.C. 552a), the Health

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

Data related to the ASCQR Program is housed in the HQR application group. CMS' HQR is a General Support System (GSS) housing protected health information (PHI). Users who access CMS' HQR system are identity-managed to permit access to the system and have role-based restrictions (including log-in and password) to the data they can see. The System of Records Notice (SORN) in use for the quality programs including the ASCQR Program is MBD 09-70-0536, as modified on February 14, 2018 (83 FR 6591).

11. Sensitive Questions

There are no questions of a sensitive nature associated with these forms.

12. Burden Estimate (Total Hours & Wages)

(a) Background

In the CY 2026 OPPI/ASC proposed rule, we proposed to remove three measures that would impact previously approved burden estimates: (1) the FCHE measure, beginning with the CY 2025 reporting period/CY 2027 payment determination; (2) the Screening for SDOH measure, beginning with the CY 2025 reporting period; and (3) the Screen Positive Rate for SDOH measure, beginning with the CY 2025 reporting period. We also proposed to adopt the Information Transfer PRO-PM beginning with voluntary reporting for the CY 2027 and CY 2028 reporting periods, followed by mandatory reporting beginning with the CY 2029 reporting period/CY 2031 payment determination. We did not propose any other measure removal or adoptions, or other policies, which would have an impact on previously approved burden estimates.

We discuss other program updates proposed in the CY 2026 OPPI/ASC proposed rule which would not affect information collection burden under OMB control number 0938-1270 in section B.1.a.

(b) Burden for the CY 2027 Payment Determination

Our currently approved burden estimates assumed that 4,475 ASCs would report data to the ASCQR Program. Based on the most recent analysis of the CY 2025 payment determination data, we found that, of the 6,012 ASCs that were actively billing Medicare, 4,271 were required to participate in the ASCQR Program. Of the 1,741 ASCs not required to participate in the program, 319 ASCs did so and met full requirements. On this basis, we estimate that 4,590 ASCs (4,271 + 319) will submit data for the ASCQR Program for the CY 2026 reporting period/CY 2028 payment determination. For purposes of burden estimation, we assume all activities

associated with the ASCQR 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 submission of data to clinical registries and the completion of any of the other applicable forms associated with activities related to the ASCQR Program.

OMB has currently approved 217,791 hours under OMB control number 0938-1270, accounting for information collection burden experienced by approximately 4,475 ASCs for the CY 2027 payment determination. As shown in Table 3, using our updated assumption of 4,590 ASCs and updated wage rates, we estimate a revised baseline burden of 224,235 hours at a cost of \$6,917,986 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 ASCs. We also note that any burden related to claims more generally is accounted for under the Health Insurance Common Claims Form and Supporting Regulations under OMB control number 0938-1197 (expiration date October 31, 2027).

Table 3. Currently Approved Burden Estimates for the ASCQR Program Measure Set and Other Activities for the CY 2027 Payment Determination

<i>Measure Set</i>	<i>Estimated time per record (minutes) - CY 2027 payment determination</i>	<i>Number of reporting quarters per year - CY 2027 payment determination</i>	<i>Number of respondents</i>	<i>Average number of records per ASC per quarter</i>	<i>Annual burden (hours) per ASC</i>	<i>Total Burden Hours for CY 2027 payment determination</i>
Web-Based Measures						
Patient Burn (Reporting)	10	1	4,590	1	0.167	765
Patient Fall (Reporting)	10	1	4,590	1	0.167	765
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (Reporting)	10	1	4,590	1	0.167	765
All-Cause Hospital Transfer/Admission (Reporting)	10	1	4,590	1	0.167	765
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	4,590	1	0.167	765
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Chart Abstraction)	2.92	1	4,590	63	3.1	14,169
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Reporting)	10	1	918	1	0.167	153

<i>Measure Set</i>	<i>Estimated time per record (minutes) - CY 2027 payment determination</i>	<i>Number of reporting quarters per year - CY 2027 payment determination</i>	<i>Number of respondents</i>	<i>Average number of records per ASC per quarter</i>	<i>Annual burden (hours) per ASC</i>	<i>Total Burden Hours for CY 2027 payment determination</i>
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Chart Abstraction)	2.92	1	918	63	3.1	2,834
Normothermia Outcome (Reporting)	10	1	4,590	1	0.167	765
Normothermia Outcome (Chart Abstraction)	2.92	1	4,590	63	3.1	14,169
Unplanned Anterior Vitrectomy (Reporting)	10	1	4,590	1	0.167	765
Unplanned Anterior Vitrectomy (Chart Abstraction)	2.92	1	4,590	7	0.343	1,574
Facility Commitment to Health Equity (Reporting)	10	1	4,590	1	0.167	765
Screening for SDOH (Voluntary Patient Surveys)	2	1	5,467,838	1	0.033	182,261
Screening for SDOH (Voluntary Reporting)	10	1	2,295	1	0.167	383
Screen Positive Rate for SDOH (Voluntary Reporting)	10	1	2,295	1	0.167	383
Web-Based Measures Subtotal						222,045
PRO-PM						
THA/TKA (Patient Survey)	7.25	2	18,124	1	0.12083	2,190
THA/TKA (Reporting)*	10	0	0	0	0	0
PRO-PM Subtotal						0
Total Burden Hours						224,235
Total Burden @ Individual labor rate (\$25.63)						\$4,727,479
Total Burden @ Medical Records Specialist labor rate (\$55.06)						\$2,190,507

*ASCs do not begin reporting measure data for this measure until the CY 2026 reporting period.

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

(c) 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” (SOC 29-2072).⁵ 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

⁵ 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>.

widely in the literature. Nonetheless, we believe that doubling the hourly wage rate ($\$27.53 \times 2 = \55.06) to estimate total cost is a reasonably accurate estimation method. Accordingly, unless otherwise specified, we will calculate cost burden to hospitals using a wage plus benefits estimate of \$55.06 per hour throughout the discussion in this section of this rule for the ASCQR Program.

(d) Web-Based Measures Burden

Certain ASCQR Program measures have the data obtained via chart abstraction and the aggregate results are submitted via a web-based tool. For those measures which address rare, adverse patient-safety events (“Patient Burn,” “Patient Fall,” “Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant,” and All-Cause Hospital Transfer/Admission”) based upon the most recent payment determination for CY 2026, we conservatively, i.e., overestimate, for burden estimate purposes that there will be at most one case per month, per web-based measure, per ASC.

For the standard clinical procedure outcome measures (Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients, Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, and Normothermia Outcome) we estimate that each participating ASC will abstract and submit data for the minimum yearly sample size of 63. Thus, we estimate that each participating ASC will spend 2.92 minutes (0.049 hours) per case to collect and submit the data for the minimum required yearly sample size of 63 as designated in the ASCQR Program Specifications Manual. For the mandatory Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients and Normothermia Outcome measures, we estimate an annual burden of 3.1 hours (0.049 hours x 63 cases) for each ASC. We estimate an annual burden of 14,169 hours (4,590 ASCs x 3.1 hours) and \$780,145 (14,169 hours x \$55.06) for each measure. For the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure, we estimate an annual burden estimate of 2,834 hours (4,590 ASCs x 20 percent x 3.1 hours) at a cost of \$156,040 (2,834 hours x \$55.06) for all voluntarily participating ASCs.

For the rare adverse surgical event measure, Unplanned Anterior Vitrectomy, we use an overestimated average number of cases reported per ASC to estimate chart-abstraction burden, due to skewed data distribution. Based on the most recent data from the CY 2023 reporting period, we estimate each ASC will be required to abstract data from an average of 7 cases per year. We estimate an annual burden of 0.343 hours (0.049 hours x 7 cases) for each ASC and an annual burden of 1,574 hours (4,590 ASCs x 0.343 hours) at a cost of \$86,664 (1,574 hours x \$55.06) for all ASCs for this measure.

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

Consistent with prior years, we estimate that each participating ASC will spend 10 minutes per measure per year to collect and submit the data via the HQR system secure portal. For mandatory measures, we estimate a total annual burden estimate for all ASCs of 765 hours (0.167 hours/measure x 4,590 ASCs) at a cost of \$42,121 (765 hours x \$55.06) per measure. For the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure, we estimate a total annual burden estimate for all voluntarily participating ASCs of 153 hours (4,590 ASCs x 20 percent x 0.167 hours) at a cost of \$8,424 (153 hours × \$55.06).

In the CY 2026 OPPS/ASC proposed rule, we proposed to remove the FCHE, the Screening for SDOH, and the Screen Positive for SDOH measures beginning with the CY 2025 reporting period.

Table 4. Estimated Burden for the Web-Based Measure Reporting and Submission Requirements for the CY 2028 Payment Determination and Subsequent Years

<i>Web-Based Measure Reporting</i>	<i>Estimated time per record (minutes)</i>	<i>Number reporting quarters per year</i>	<i>Number of respondents</i>	<i>Average number records per ASC per quarter</i>	<i>Annual burden (hours) per ASC</i>	<i>Total Burden Hours for all respondents</i>
CY 2028 Payment Determination						
Patient Burn (Reporting)	10	1	4,590	1	0.167	765
Patient Fall (Reporting)	10	1	4,590	1	0.167	765
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (Reporting)	10	1	4,590	1	0.167	765
All-Cause Hospital Transfer/Admission (Reporting)	10	1	4,590	1	0.167	765
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Reporting)	10	1	4,590	1	0.167	765
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Chart Abstraction)	2.9	1	4,590	63	3.1	14,169
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Reporting)	10	1	918	1	0.167	153
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Chart Abstraction)	2.9	1	918	63	3.1	2,834
Normothermia Outcome (Reporting)	10	1	4,590	1	0.167	765
Normothermia Outcome (Chart Abstraction)	2.9	1	4,590	63	3.1	14,169
Unplanned Anterior Vitrectomy (Reporting)	10	1	4,590	1	0.167	765

<i>Web-Based Measure Reporting</i>	<i>Estimated time per record (minutes)</i>	<i>Number reporting quarters per year</i>	<i>Number of respondents</i>	<i>Average number records per ASC per quarter</i>	<i>Annual burden (hours) per ASC</i>	<i>Total Burden Hours for all respondents</i>
Unplanned Anterior Vitrectomy (Chart Abstraction)	2.9	1	4,590	7	0.343	1,574
Total Burden Hours						38,254
Total Burden @ Medical Records Specialist labor rate (\$55.06)						\$2,106,265

(e) PRO-PM Measures Burden

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

The THA/TKA PRO-PM uses four sources of data for the calculation of the measure: (1) patient-reported outcome (PRO) data; (2) claims data; (3) Medicare enrollment and beneficiary data; and (4) U.S. Census Bureau survey data. We estimate no additional burden associated with claims data, Medicare enrollment and beneficiary data, and U.S. Census Bureau survey data as these data are already collected via other mechanisms such as Medicare enrollment forms, CMS-1500 form, and U.S. Census Informational Questionnaires. Many ASCs have already incorporated PRO data collection into their workflows. While we did not specify how ASCs collect PRO data for this measure, ASCs new to collecting PRO data will have multiple options for when and how they will collect these PRO data so they can best determine the mode and timing of collection that works best for their patient population.

The possible patient touchpoints for pre-operative PRO data collection include the doctor's office, pre-surgical steps such as education classes, or medical evaluations that can occur in an office or at the ASC. The modes of PRO data collection can include completion of the pre-operative surveys using electronic devices, pen and paper, mail, telephone, or through a patient portal. Post-operative PRO data collection modes are similar to pre-operative modes. The possible patient touchpoints for post-operative data collection can occur before the follow-up appointment, at the doctor's office, or after the follow-up appointment. If the patient does not or cannot attend a follow-up appointment, the modes of data collection will be completion of the post-operative survey using email, mail, telephone, or through a patient portal. Similar to other surveys like the OAS CAHPS, we believe the use of multiple data collection modes serve to maximize response rates as it allows for different patient preferences.

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

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

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/hour based on the report “Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices,” which identifies the approach for valuing time when individuals undertake activities on their own time.⁶ 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.⁷ This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 14 percent calculated by comparing pre-and post-tax income,⁸ resulting in the post-tax hourly wage rate of \$25.63/hour. Unlike our state and private sector wage adjustments, we are not adjusting patient wages for fringe benefits and other indirect costs since the individuals’ activities, if any, will occur outside the scope of their employment.

To estimate the burden of information collection for patients completing surveys for this measure, we assume that most ASCs will likely undertake PRO data collection through a screening tool incorporated into their patient intake process. We found that there were 1,082 ASCs which had an average of 67 THA/TKA paid Medicare FFS claims in CY 2024. Thus, we estimate that approximately 72,494 THA/TKA procedures will occur in ASCs each year, and that many patients could complete both the pre-operative and post-operative questionnaires. However, from our experience with using this measure in the Comprehensive Joint Replacement

⁶ Office of the Assistant Secretary for Planning and Evaluation, Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices, September 17, 2017. Available at <https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework>.

⁷ Bureau of Labor and Statistics, Usual Weekly Earnings of Wage and Salary Workers, Fourth Quarter 2024. Available at <https://www.bls.gov/news.release/pdf/wkyeng.pdf>. Accessed March 3, 2025.

⁸ 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.

model, we are also aware that not all patients who complete the pre-operative questionnaire will complete the post-operative questionnaire. For the CY 2026 and 2027 voluntary reporting periods, we assume 18,124 procedures of which patients can complete a survey (72,494 procedures \times 50 percent survey completion rate \times 50 percent of ASCs) for a total of 2,190 hours annually (18,124 possible surveys \times 0.120833 hours) at a cost of \$56,130 (2,190 hours \times \$25.63) each year. Beginning with mandatory reporting in the CY 2028 reporting period/CY 2031 payment determination, we assume 36,247 procedures of which patients can complete a survey (72,494 procedures \times 50 percent survey completion rate \times 100 percent ASC participation rate) for a total of 4,380 hours annually (36,247 possible surveys \times 0.120833 hours) at a cost of \$112,259 (4,380 hours \times \$25.63) across all ASCs that perform these procedures.

Regarding ASCs' burden related to submitting data for this measure which will be reported via the HQR System, we estimate a burden of 10 minutes per response. As shown in Table 5, ASCs will submit data associated with pre-operative surveys by March 31 of the CY following the CY in which the eligible procedures took place and will submit data associated with post-operative surveys by March 31 of the CY following the CY in which pre-operative data were submitted. Therefore, for voluntary reporting 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.

Table 5. Timeline for Patient Surveys and Measure Reporting for the THA/TKA PRO-PM in the CY 2025 Through CY 2030 Reporting Periods

Reporting Period	Patient Surveys Conducted	Measure Data Reported
CY 2025	Voluntary Pre- and Post-Operative	None
CY 2026	Voluntary Pre- and Post-Operative	Voluntary Pre-Operative (CY 2025 Surveys)
CY 2027	Voluntary Pre- and Post-Operative	Voluntary Pre- (CY 2026 Surveys) and Post-Operative (CY 2025 Surveys)
CY 2028	Mandatory Pre- and Post-Operative	Voluntary Pre- (CY 2027 Surveys) and Post-Operative (CY 2026 Surveys)
CY 2029	Mandatory Pre- and Post-Operative	Voluntary Post-Operative (CY 2027 Surveys) and Mandatory Pre-Operative (CY 2028 Surveys)
CY 2030	Mandatory Pre- and Post-Operative	Mandatory Pre- (CY 2029 Surveys) and Post-Operative (CY 2028 Surveys)

For voluntary reporting for the CY 2027 and 2028 reporting periods, we estimate that each ASC will spend 20 minutes (0.33 hours) annually (10 minutes \times 2 surveys) to collect and submit the data. For the voluntary reporting for the CY 2026 reporting period, we estimate a burden for all participating ASCs of 90 hours (0.167 hours \times 541 ASCs) at a cost of \$4,955 (90 hours \times \$55.06). For voluntary reporting for the CY 2027 and CY 2028 reporting periods, we estimate a burden for all participating ASCs of 180 hours (0.33 hours \times 541 ASCs) at a cost of \$9,911 (180

hours × \$55.06). For the CY 2029 reporting period, we estimate a burden for all participating ASCs of 271 hours $[(0.167 \text{ hours} \times 541 \text{ ASCs}) + (0.167 \text{ hours} \times 1,082 \text{ ASCs})]$ at a cost of \$14,921 $(271 \text{ hours} \times \$55.06)$. For the CY 2030 reporting period and subsequent years, we estimate a total of 361 hours $(0.33 \text{ hours} \times 1,082 \text{ ASCs})$ at a cost of \$19,877 $(361 \text{ hours} \times \$55.06)$.

In the CY 2026 OPPI/ASC proposed rule, we proposed to adopt the Information Transfer PRO-PM with voluntary reporting for the CY 2027 and CY 2028 reporting periods followed by mandatory reporting beginning with the CY 2029 reporting period/CY 2031 payment determination. The Information Transfer PRO-PM would use PRO data regarding recovery instructions, collected by ASCs 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. In addition, for ASCs that anticipate receiving more than 200 completed surveys, we proposed that these ASCs would have the option to either: (1) survey and report data on their entire eligible Information Transfer PRO-PM patient population, or (2) randomly sample their eligible Information Transfer PRO-PM patient population to collect and report data from 200 completed surveys. As submission rates among facilities may vary, we conservatively estimate that, for voluntary reporting for the CY 2027 and CY 2028 reporting periods, 50 percent of ASCs (or their third-party vendors) would obtain responses from 30 percent of patients, and, beginning with mandatory reporting for the CY 2029 reporting period, ASCs (or their third-party vendors) would obtain responses from 30 percent of patients. 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 ASCQC related to ASC patient fall benchmarking data as this metric applies to all patients rather than a subset. Since we expect that ASCs reporting data to the ASCQC will tend to be larger facilities with larger patient populations than non-reporting ASCs, we conservatively estimate that each year approximately 22,326,000 patients $(10,433,448 \text{ admissions}^{13} \div 2,145 \text{ ASCs reporting}) \times 4,590 \text{ ASCs})$ with an average of 4,864 patients per ASC $(22,326,000 \text{ admissions} \div 4,590 \text{ ASCs})$ would be eligible to be screened annually when reporting on the measure becomes mandatory.

We estimate each patient would require an average of 5 minutes (0.083 hours) to complete the survey. For voluntary reporting for the CY 2027 and CY 2028 reporting periods, we estimate a total burden for patients of 279,075 hours $(22,326,000 \text{ patients} \times 30 \text{ percent response rate} \times 50 \text{ percent of ASCs} \times 0.083 \text{ hours per patient surveyed})$ at a cost of \$7,152,692 $(279,075 \text{ hours} \times \$25.63)$. For mandatory reporting beginning with the CY 2029 reporting period, we estimate an annual total burden for patients of 558,150 hours $(22,326,000 \text{ patients} \times 30 \text{ percent response rate} \times 0.083 \text{ hours per patient})$ at a cost of \$14,305,385 $(558,150 \text{ hours} \times \$25.63)$ or \$3,117 per ASC $(\$14,305,385 \div 4,590 \text{ ASCs})$.

Measure data would 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 ASCQR Program, we estimate a burden of 10 minutes (0.167 hours) per ASC to report measure data. For voluntary reporting for the CY 2027 and CY 2028 reporting periods, we estimate an annual burden for participating ASCs of 383 hours $(4,590 \text{ HOPDs} \times 50 \text{ percent of ASCs} \times 0.167 \text{ hours})$ at a cost of \$21,088 $(383 \text{ hours} \times \$55.06)$. For mandatory reporting beginning with the CY 2029 reporting period, we estimate an annual burden for all ASCs of 765 hours $(4,590 \text{ ASCs} \times 0.167 \text{ hours})$ at a cost of \$42,121 $(765 \text{ hours} \times \$55.06)$.

Table 6. Estimated Burden for the PRO-PM Reporting and Submission Requirements for the CY 2026 through CY 2030 Reporting Periods

<i>PRO-PM Measure Reporting</i>	<i>Estimated time per record (minutes)</i>	<i>Number reporting quarters per year</i>	<i>Number of Respondents</i>	<i>Average number records per Respondent per quarter</i>	<i>Annual burden (hours) per Respondent</i>	<i>Total Annual hours for all Respondents</i>
CY 2026 Reporting Period						
THA/TKA (Voluntary Patient Surveys)	7.25	2	18,124	1	0.12083	2,190
THA/TKA (Voluntary Measure Reporting)	10	1	541	1	0.167	90
Total Burden Hours						2,280
Total Burden @ Individual labor rate (\$25.63)						\$56,130
Total Burden @ Medical Records Specialist labor rate (\$55.06)						\$4,955
CY 2027 Reporting Period						
THA/TKA (Voluntary Patient Surveys)	7.25	2	18,124	1	0.12083	2,190
THA/TKA (Voluntary Measure Reporting)	10	2	541	1	0.33	180
Information Transfer (Voluntary Patient Surveys)	5	1	3,348,900	1	0.083	279,075
Information Transfer (Voluntary Measure Reporting)	10	1	2,295	1	0.167	383
Total Burden Hours						281,828
Total Burden @ Individual labor rate (\$25.63)						\$7,208,822
Total Burden @ Medical Records Specialist labor rate (\$55.06)						\$30,999
CY 2028 Reporting Period						
THA/TKA (Mandatory Patient Surveys)	7.25	2	36,247	1	0.12083	4,380
THA/TKA (Voluntary Measure Reporting)	10	2	541	1	0.33	180
Information Transfer (Voluntary Patient Surveys)	5	1	3,348,900	1	0.083	279,075
Information Transfer (Voluntary Measure Reporting)	10	1	2,295	1	0.167	383
Total Burden Hours						284,018
Total Burden @ Individual labor rate (\$25.63)						\$7,264,951
Total Burden @ Medical Records Specialist labor rate (\$55.06)						\$30,999
CY 2029 Reporting Period						
THA/TKA (Mandatory Patient Surveys)	7.25	2	36,247	1	0.12083	4,380
THA/TKA (Voluntary Measure Reporting)	10	1	541	1	0.167	90
THA/TKA (Mandatory Measure Reporting)	10	1	1,082	1	0.167	181

<i>PRO-PM Measure Reporting</i>	<i>Estimated time per record (minutes)</i>	<i>Number reporting quarters per year</i>	<i>Number of Respondents</i>	<i>Average number records per Respondent per quarter</i>	<i>Annual burden (hours) per Respondent</i>	<i>Total Annual hours for all Respondents</i>
Information Transfer (Mandatory Patient Surveys)	5	1	6,697,800	1	0.083	558,150
Information Transfer (Mandatory Measure Reporting)	10	1	4,590	1	0.167	765
Total Burden Hours						563,566
Total Burden @ Individual labor rate (\$25.63)						\$14,417,644
Total Burden @ Medical Records Specialist labor rate (\$55.06)						\$57,042
CY 2030 Reporting Period and Subsequent Years						
THA/TKA (Mandatory Patient Surveys)	7.25	2	36,247	1	0.12083	4,380
THA/TKA (Mandatory Measure Reporting)	10	2	1,082	1	0.33	361
Information Transfer (Mandatory Patient Surveys)	5	1	6,697,800	1	0.083	558,150
Information Transfer (Mandatory Measure Reporting)	10	1	4,590	1	0.167	765
Total Burden Hours						563,656
Total Burden @ Individual labor rate (\$25.63)						\$14,417,644
Total Burden @ Medical Records Specialist labor rate (\$55.06)						\$61,998

(f) Claims-Based Measure Burden

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

(g) Survey-Based Measure Burden

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

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

As shown in Tables 7 and 8, in summary, under OMB control number 0938-1270, we estimate a total annual information collection burden of 40,534 hours at a cost of \$2,167,350 for the CY 2026 reporting period/CY 2028 payment determination. We also estimate an annual decrease of 151,223 hours and \$3,889,530 associated with our proposals and updated burden estimates described above related to this information collection (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 7. Total Burden Hours for the CY 2028 through CY 2031 Payment Determinations

Information Collection	CY2028	Difference from Currently Approved	CY2029	Difference from Currently Approved	CY2030	Difference from Currently Approved	CY2031	Difference from Currently Approved
Patient Burn	765	19	765	19	765	19	765	19
Patient Fall	765	19	765	19	765	19	765	19
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	765	19	765	19	765	19	765	19
All-Cause Hospital Transfer/Admission	765	19	765	19	765	19	765	19
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	14,934	374	14,934	374	14,934	374	14,934	374
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	2,987	75	2,987	75	2,987	75	2,987	75
Normothermia Outcome	14,934	374	14,934	374	14,934	374	14,934	374
Unplanned Anterior Vitrectomy	2,339	58	2,339	58	2,339	58	2,339	58
Facility Commitment to Health Equity	0	-746	0	-746	0	-746	0	-746
Screening for SDOH	0	-711,479	0	-711,479	0	-711,479	0	-711,479
Screen Positive Rate for SDOH	0	-746	0	-746	0	-746	0	-746
THA/TKA PRO-PM*	2,280	927	2,370	944	4,560	1,858	4,651	1,876
Information Transfer PRO-PM	0	0	279,458	279,458	279,458	279,458	558,915	558,915
TOTAL	40,534	-711,087	320,082	-431,612	322,272	-430,698	601,820	-151,223

* The payment determination year for the THA/TKA PRO-PM is three years after the reporting period (i.e. the CY 2026 reporting period impacts the CY 2029 payment determination). However, in order to accurately summarize annual burden for the ASCQR Program, in Tables 7 and 8 the burden associated with the THA/TKA PRO-PM is included in the payment determination two years following the reporting period.

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

Information Collection	CY2028	Difference from Currently Approved	CY2029	Difference from Currently Approved	CY2030	Difference from Currently Approved	CY2031	Difference from Currently Approved
Patient Burn	\$42,121	\$1,046	\$42,121	\$1,046	\$42,121	\$1,046	\$42,121	\$1,046
Patient Fall	\$42,121	\$1,046	\$42,121	\$1,046	\$42,121	\$1,046	\$42,121	\$1,046
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	\$42,121	\$1,046	\$42,121	\$1,046	\$42,121	\$1,046	\$42,121	\$1,046
All-Cause Hospital Transfer/Admission	\$42,121	\$1,046	\$42,121	\$1,046	\$42,121	\$1,046	\$42,121	\$1,046
Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	\$822,266	\$20,592	\$822,266	\$20,592	\$822,266	\$20,592	\$822,266	\$20,592
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	\$164,464	\$4,130	\$164,464	\$4,130	\$164,464	\$4,130	\$164,464	\$4,130
Normothermia Outcome	\$822,266	\$20,592	\$822,266	\$20,592	\$822,266	\$20,592	\$822,266	\$20,592
Unplanned Anterior Vitrectomy	\$128,785	\$3,193	\$128,785	\$3,193	\$128,785	\$3,193	\$128,785	\$3,193
Facility Commitment to Health Equity	\$0	(\$41,075)	\$0	(\$41,075)	\$0	(\$41,075)	\$0	(\$41,075)
Screening for SDOH	\$0	(\$18,257,162)	\$0	(\$18,257,162)	\$0	(\$18,257,162)	\$0	(\$18,257,162)
Screen Positive Rate for SDOH	\$0	(\$41,075)	\$0	(\$41,075)	\$0	(\$41,075)	\$0	(\$41,075)
THA/TKA PRO-PM	\$61,085	\$24,230	\$66,041	\$25,166	\$122,170	\$48,592	\$127,181	\$49,583
Information Transfer PRO-PM	\$0	\$0	\$7,173,780	\$7,173,780	\$7,173,780	\$7,173,780	\$14,347,505	\$14,347,505
TOTAL	\$2,167,350	(\$18,262,389)	\$9,346,086	(\$11,087,673)	\$9,402,216	(\$11,064,247)	\$16,580,951	(\$3,889,530)

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

13. Capital Costs (Maintenance of Capital Costs)

For ASCs that are not currently collecting Facility-Level THA/TKA PRO-PM or Information Transfer PRO-PM data, there will be some non-recurring costs associated with changes in workflow and information systems to collect the data. The extent of these costs is difficult to quantify as different hospitals may utilize different modes of data collection (for example paper-based, electronically patient-directed, clinician-facilitated, etc.). While we assume the majority of ASCs will report data for this measure via CMS' HQR System, we assume some ASCs may elect to submit measure data via a third-party CMS-approved survey vendor, for which there are associated costs. Under OMB control number 0938-1240 for the OAS CAHPS Survey measure (expiration date November 30, 2026), an estimate of approximately \$4,000 per hospital is used to account for these costs.

14. Cost to Federal Government

The cost to the Federal Government for maintaining program activities is for supporting data system architecture, data storage, maintenance and updating of information technology infrastructure on the HQR system secure portal, providing ongoing technical assistance to ASCs and data vendors, calculation of claims-based measures, measure development and maintenance, the provision of ASCs with feedback and preview reports, as well as costs associated with public reporting. These costs are estimated at \$10,050,000 annually for the validation and quality reporting contracts. Additionally, there is one FTE assigned full-time in a lead position to this program. Using a GS-14 step 5 salary, that provides a rough estimate of \$161,486 plus benefits (30%) of \$48,446 or \$209,932 for the federal government labor cost for this program year and subsequent years.

Total estimated cost to the Federal Government for the ASCQR Program is \$10,259,932.

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

15. Program or Burden Changes

We previously requested total annual burden estimates under this OMB control number for the CY 2026 reporting period/CY 2028 payment determination of 751,621 hours at a cost of \$19,630,720 as a result of policies finalized in the CY 2025 OPPTS/ASC final rule. Accounting for updated wage rates, the total cost of \$19,630,720 increases to \$20,429,739. For the CY 2026 reporting period/CY 2028 payment determination, based on the proposed measure removals and adoptions in the CY 2026 OPPTS/ASC proposed rule, we estimate a total burden of 40,534 hours at a cost of \$2,167,350 (a decrease of 711,087 hours and \$18,262,38 from our previous request). This burden estimate also represents a decrease of 577,985 hours from the currently approved burden estimate of 618,519 hours for the CY 2025 reporting period/CY 2027 payment determination.

The proposed removal of the FCHE measure would result in a total estimated burden decrease of 746 hours and \$41,075 beginning with the CY 2027 payment determination. The proposed

removal of the Screening for SDOH and Screen Positive Rate for SDOH measures would result in a total estimated burden decrease of 711,479 hours and \$18,257,162 and 746 hours and \$41,075, respectively, beginning with the CY 2025 reporting period. The proposed adoption of the Information Transfer PRO-PM would result in a total estimated burden increase of 558,915 hours and \$14,347,505 beginning with the CY 2031 payment determination. The updated number of annual THA/TKA procedures and ASCs performing these procedures will result in an estimated increase of 1,876 hours at a cost of \$49,583 for the CY 2031 payment determination and 1,892 hours at a cost of \$50,464 for the CY 2032 payment determination (note that Tables 7 and 8 do not include burden for the CY 2032 payment determination).

Accounting for the impact of the proposed measure adoptions in the CY 2026 OPPS/ASC proposed rule and updated burden estimates, our updated estimate of the number of ASCs results in an annual burden increase of 957 hours and \$52,694 through the CY 2031 payment determination. The aggregate decrease from the CY 2028 payment determination through the CY 2031 payment determination due to these proposed measure removals, adoptions, and adjustments is 151,223 hours ($-746 - 711,479 - 746 + 558,915 + 1,876 + 957$) and \$3,889,530 ($-\$41,075 - \$18,257,162 - \$41,075 + \$14,347,505 + \$49,583 + \$52,694$) as shown in Tables 7 and 8 for the CY 2028 through CY 2031 payment determinations.

16. Publication

As required by authorizing statute, quality measure data are made publicly available after providing ASCs the opportunity to review their data. The goal of the data collection is to tabulate and publish ASC-specific data. ASC data from these initiatives are currently used to populate CMS' Provider Data Catalog available at data.cms.gov. We note, however, 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 ASCQR Program pages used to document our measure specifications and reporting guidance.

18. Certification Statement

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

19. Collections of Information Employing Statistical Methods

This information collection does not require the use of statistical methods. However, to reduce burden, facilities may 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.