Supporting Statement Part A

Implementation of Medicare Programs; - Medicare Promoting Interoperability Program (CMS-10552)

Background

The Centers for Medicare & Medicaid Services (CMS) is requesting approval to collect information from eligible hospitals and critical access hospitals (CAHs). We have proposed changes to this program as discussed in the FY 2024 Inpatient Prospective Payment System (IPPS)/Long-term Care Hospital Prospective Payment System (LTCH PPS) proposed rule. This is a revision of the information collection request.

The American Recovery and Reinvestment Act of 2009 (Recovery Act) (Pub. L. 111-5) was enacted on February 17, 2009. Title IV of Division B of the Recovery Act amended Titles XVIII and XIX of the Social Security Act (the Act) by establishing incentive payments to eligible professionals (EPs), eligible hospitals and CAHs, and Medicare Advantage (MA) organizations participating in the Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology (CEHRT). These Recovery Act provisions, together with Title XIII of Division A of the Recovery Act, may be cited as the "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act."

The HITECH Act created incentive programs for EPs, eligible hospitals including CAHs, and MA organizations in the Medicare Fee-for-Service (FFS), and Medicaid programs that successfully demonstrated meaningful use of CEHRT. In their first payment year, Medicaid EPs, eligible hospitals including MA organizations and CAHs could adopt, implement, or upgrade to certified EHR technology. It also allowed for negative payment adjustments in the Medicare FFS and MA programs starting in 2015 for EPs, eligible hospitals including MA organizations and CAHs participating in Medicare that are not meaningful users of CEHRT. The Medicaid Promoting Interoperability Program did not authorize negative payment adjustments, but its participants were eligible for incentive payments until December 31, 2021 when the program ended.

In CY 2017, we began collecting data from eligible hospitals and CAHs to determine the application of the Medicare payment adjustments. This information collection was also used to make incentive payments to eligible hospitals in Puerto Rico from 2016 through 2021. At this time, Medicare eligible professionals no longer reported to the EHR Incentive Program, as they began reporting under the Merit-based Incentive Payment System's (MIPS) Promoting Interoperability Performance Category. In 2019, the EHR Incentives Program for eligible hospitals and CAHs was subsequently renamed the Medicare Promoting Interoperability Program. In subsequent years, we have focused on balancing reporting burden for eligible hospitals and CAHs while also implementing changes designed to incentivize the advanced use of CEHRT to support health information exchange, interoperability, advanced quality measurement, and maximizing clinical effectiveness and efficiencies.

In the FY 2024 IPPS/LTCH PPS proposed rule, we did not propose any changes for eligible hospitals and CAHs that attest to CMS under the Medicare Promoting

Interoperability Program that we expect to affect our collection of information burden estimates. We proposed the following policies which will not affect the information collection burden: (i) to adopt three electronic clinical quality measures (eCQMs) beginning with the CY 2025 reporting period: (1) Hospital Harm – Pressure Injury eCQM; (2) Hospital Harm – Acute Kidney Injury eCQM; and (3) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CMT) in Adults eCQM; (ii) to modify the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure to require eligible hospitals and CAHs to submit a "yes" attestation to fulfill the measure beginning with the EHR reporting period in CY 2024; and (iii) to establish an EHR reporting period of a minimum of any continuous 180-day period in CY 2025.

We note in the *CMS Advancing Interoperability and Improving Prior Authorization Processes for MA Organizations and Medicaid Managed Care Plans, State Medicaid Agencies, State CHIP Agencies, CHIP Managed Care Entities, and Issuers of QHPs in the Federally-Facilitated Exchanges Proposed Rule* (CMS-0057-P), we have proposed for the Medicare Promoting Interoperability Program for eligible hospitals and CAHs a new electronic prior authorization measure. This measure would require health care providers to request a prior authorization, electronically, using data from CEHRT using a payer's Prior Authorization API. This measure, called "Electronic Prior Authorization" is under the Health Information Exchange (HIE) objective, proposed to begin with the CY 2027 EHR reporting period. In CY 2027, the measure is proposed to be submitted as an attestation, with a modification that for subsequent years, data would be submitted as numerator/denominator.

We are seeking approval for information collections covering calendar years 2024, 2025, and 2026; therefore, we have not included the burden associated with this proposal in our burden estimates discussed in section A.12.

A. Justification

1. Need and Legal Basis

This information collection serves to implement the HITECH Act. We have developed objectives and measures to collect data and have the healthcare providers attest or report data as applicable to determine that they have met the requirements of the Medicare Promoting Interoperability Program. Eligible hospitals and CAHs must successfully demonstrate meaningful use under the Medicare Promoting Interoperability Program to avoid a downward payment adjustment.

2. Information Users

The collection of information under this data collection is used to validate compliance with the requirements for being a successful meaningful user under the Medicare Promoting Interoperability Program. Participants attest or report data as applicable to the required objectives and measures to meet the required threshold for being considered a Meaningful User. They must also electronically submit clinical quality measure data

(eCQMs). If it is determined that the participant is a not a Meaningful User, they would be subject to a downward payment adjustment. The collection of information burden analysis in the FY 2024 IPPS/LTCH PPS final rule focuses on eligible hospitals and CAHs that report on the objectives, measures, and eCQMs under the Medicare Promoting Interoperability Program.

We use the information collected from measure submissions to gain a better understanding of how eligible hospitals and CAHs are utilizing CEHRT and its functionality. We use the information collected from eCQM data to determine its impact on care delivery for Medicare beneficiaries. Our goal is to continue to advance the meaningful use of health information technology with our priority to continue promoting interoperability through health information exchange among various health systems' EHRs.

3. Improved Information Technology

Attestation, or data reporting as applicable, is completed on an annual basis via an online submission form. Outside of this online attestation, there are no physical nor additional forms used. Developers and CMS commonly refer to this program-specific format as the Attestation Screens, which are only open for completion by eligible hospitals and CAHs between January and March (exact dates may vary due to calendar).

4. Duplication of Similar Information

There is no duplication of effort on information associated with this collection.

5. Small Businesses

The only small businesses affected by this effort will be those small eligible hospitals and CAHs (we define a "small hospital" as one with 1-99 inpatient beds) that participate in the Medicare Promoting Interoperability Program. Ninety-nine percent of all hospitals have adopted EHRs. We have minimized the impact on these entities by allowing all healthcare providers to apply for a significant hardship exception if they meet certain hardship criteria. This will help to minimize the impact on healthcare providers that are unable to meet the program requirements. Eligible hospitals and CAHs would need to submit a new application for subsequent years and no eligible hospital or CAH can be granted an exception for more than five years (Section 1886(b)(3)(B)(ix)(II) of the Social Security Act). Please note each hardship is reviewed on a case-by-case basis.

6. Less Frequent Collection

We have designed the collection of information under the Medicare Promoting Interoperability Program to be the minimum necessary for eligible hospitals and CAHs to demonstrate the meaningful use of CEHRT. To implement the meaningful use provisions of the HITECH Act and avoid downward payment adjustments under the Medicare Promoting Interoperability Program, eligible hospitals and CAHs are required to attest to the identification of the CEHRT used, satisfaction of the applicable objectives and

measures, and electronic reporting of quality measures annually. Less frequent information collection would impede efforts to establish compliance with the HITECH Act.

7. Special Circumstances

There are no special circumstances.

8. Federal Register Notice/Outside Consultation

The FY 2024 IPPS/LTCH PPS final rule (RIN 0938-AV08, CMS-1785-F) published on August 28, 2023 (88 FR 58640).

The 60-day Federal Register notice published May 1, 2023 (88 FR 26658).

9. Payment/Gift to Respondent

No gifts will be given to respondents for participation. The program has historically utilized incentive payments to Medicare and Medicaid providers who successfully demonstrated meaningful use, however, these positive incentive adjustments ended in CY 2021. Medicare is currently the one remaining program with only a downward payment adjustment.

The HITECH Act authorized incentive payments under Medicare and Medicaid for the adoption and meaningful use of CEHRT. Incentive payments under Medicare were available to eligible hospitals and CAHs for certain payment years (as authorized under sections 1886(n) and 1814(l) of the Act, respectively) if they successfully demonstrated meaningful use of CEHRT, which included reporting on eCQMs using CEHRT. Incentive payments were available to MA organizations under section 1853(m)(3) of the Act for certain affiliated hospitals that successfully demonstrated meaningful use of CEHRT. In accordance with the timeframe set forth in the statute, these incentive payments under Medicare are no longer available. The last reporting year that Puerto Rico eligible hospitals could receive an incentive payment was in 2020 (FY 2021 payment year), and reporting year 2021 (FY 2022 payment year) was the first year where they would be subject to a downward/negative payment adjustment for failing to demonstrate meaningful use of CEHRT.

10. Confidentiality

We pledge privacy to the extent provided by law. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted. In addition, the tools used for transmission of data are considered confidential forms of communication, and there are safeguards in place in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. The data collected will be for CMS internal use only and will not be published, except as finalized for public display under section 1886(n)(4)(B) of the Act, which requires the Secretary to post on the CMS website, in an easily understandable format, a list of the names of the eligible hospitals and CAHs that are meaningful EHR users, and other relevant data as determined appropriate by the Secretary.

11. Sensitive Questions

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

12. Burden Estimate (Total Hours and Wages)

a. Background

Our burden estimates are based on an assumption of 3,150 eligible hospitals and 1,350 CAHs based on data from the FY 2021 reporting period, for a total number of 4,500 respondents.

In the FY 2023 IPPS/LTCH PPS final rule (87 FR 49393), we estimated that the labor performed could be accomplished by Medical Records and Health Information Technician staff based on a mean hourly wage in general medical and surgical hospitals of $21.20 per hour. We note that since then, and as of the publication date of the FY 2024 IPPS/LTCH PPS final rule, this Bureau of Labor Statistics occupation category has been replaced with medical record specialists and more recent wage data reflecting a median hourly wage of $22.43 per hour. We calculated the cost of overhead, including fringe benefits, at 100% of the mean hourly wage, consistent with previous years. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly between employers, and because methods of estimating these costs vary widely in the literature. Nonetheless, we believe that doubling the hourly wage ($22.43 × 2 = $44.86) to estimate total cost is a reasonably accurate estimation method. As a result of the availability of this more recent wage data, we have updated the wage rate used in these calculations in the FY 2024 IPPS/LTCH PPS final rule and this corresponding PRA package to $44.86.

Table 1 below summarizes the currently approved burden for the CY 2024 EHR reporting period. We are not making any changes or adjustments to the burden hour estimates currently approved under OMB 0938-1278.

Table 1: Medicare Promoting Interoperability Program Estimated Annual Information Collection Burden Per Respondent for the CY 2024, 2025, and 2026 EHR Reporting Period:

Objective	Measure	Burden Estimate per Eligible Hospital/CAH
Protect Patient Health Information	Security Risk Analysis	6 hours
	SAFER Guides	1 minute
Electronic Prescribing	e-Prescribing	10.5 minutes
	Query of Prescription Drug Monitoring Program (PDMP)	

Objective	Measure	Burden Estimate per Eligible Hospital/CAH
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	10 minutes
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	
	OR	
	Health Information Exchange Bi-Directional Exchange	
	OR	
	Enabling Information Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) measure	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	10 minutes
Public Health and Clinical Data Exchange	Report the following 5 measures: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • Antimicrobial Use and Antimicrobial Resistance (AUR) Surveillance Measure	3 minutes
	Submit Level of Active Engagement	
	Report one of the following measures (BONUS): • Public Heath Registry Reporting • Clinical Data Registry Reporting	
Total Burden Estimate per Eligible Hospital and CAH		**6 hours 35 minutes**

b. Measure Reporting and Submission Requirements for the Protect Patient Health Information Objective

We continue to estimate it will require eligible hospitals and CAHs approximately 6 hours to conduct or review a security risk analysis including addressing the security (to include encryption) of data created or maintained by CEHRT, implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process as finalized in the *Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017* final rule (80 FR 62917). We also continue to estimate it will require eligible hospitals and CAHs approximately 1 minute to respond "yes" or "no" for

the SAFER Guides Reporting measure as finalized in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45515).

In the FY 2024 IPPS/LTCH PPS final rule, we finalized our proposal to modify the SAFER Guides measure to require eligible hospitals and CAHs to submit a "yes" attestation to fulfill the measure beginning with the EHR reporting period in CY 2024. In the CY 2022 IPPS/LTCH PPS final rule, we adopted the SAFER Guides measure and required eligible hospitals and CAHs to attest "yes" or "no" as to whether they completed an annual self-assessment on each of the nine SAFER Guides at any point during the calendar year in which their EHR reporting period occurs (86 FR 45479 through 45481). Because we are not proposing to modify the information that eligible hospitals and CAHs will be required to submit but are instead requiring an attestation of "yes", we are not making any changes to our currently approved burden estimates.

We estimate the total burden for this Objective to be 27,075 hours (6.017 hours x 4,500 hospitals) at a cost of $1,214,585 (27,075 hours x $44.86).

c. Measure Reporting and Submission Requirements for the Electronic Prescribing Objective

We continue to estimate that eligible hospitals and CAHs will require 10 minutes to report the Electronic Prescribing measure as finalized in the *Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017* final rule (80 FR 62917). We also continue to estimate that eligible hospitals and CAHs require 0.5 minutes to report the Query of PDMP measure as finalized in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49393 through 49394). We are increasing our burden estimate for the Electronic Prescribing Objective from 10 minutes to 10.5 minutes (0.175 hours) to report both the e-Prescribing and Query of PDMP measures.

We estimate the total burden for this Objective of 788 hours across all eligible hospitals and CAHs (0.175 hours × 4,500 eligible hospitals and CAHs) annually at a cost of $35,350 (788 hours x $44.86).

d. Measure Reporting and Submission Requirements for the Health Information Exchange Objective

We finalized in the FY 2022 IPPS/LTCH PPS final rule that eligible hospitals and CAHs may elect to report either the Health Information Exchange (HIE) Bi-Directional Exchange measure as a yes/no attestation to the HIE Objective as an optional alternative to the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures (86 FR 45465 through 45470). In the FY 2023 IPPS/LTCH PPS final rule, we added the Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) measure as an optional alternative to the three existing measures (Support

Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure, or the HIE Bi-Directional Exchange measure) (87 FR 49395).

We continue to estimate eligible hospitals and CAHs will require 10 minutes (0.167 hours) to report one of the three alternatives. Therefore, we estimate a total information collection burden for this Objective of 750 hours (0.167 hours x 4,500 hospitals) at a cost of $33,645 (750 hours x $44.86).

e. Measure Reporting and Submission Requirements for the Provider to Patient Exchange Objective

We continue to estimate eligible hospitals and CAHs will require 10 minutes (0.167 hours) to report the Provide Patients Electronic Access to Their Health Information measure. Therefore, we estimate a total information collection burden for this Objective of 750 hours (0.167 hours x 4,500 hospitals) at a cost of $33,645 (750 hours x $44.86).

f. Measure Reporting and Submission Requirements for the Public Health and Clinical Data Exchange Objective

We previously estimated eligible hospitals and CAHs would require 3 minutes (0.05 hours) to report five measures and submit the level of active engagement under the Public Health and Clinical Data Exchange Objective. In order to accurately capture the maximum burden that eligible hospitals and CAHs may experience for this Objective, we are revising our previous burden calculation to include an additional 0.5 minutes for attesting to one of the optional bonus Public Heath Registry Reporting or Clinical Data Registry Reporting measures.

In the FY 2022 IPPS/LTCH PPS final rule, we finalized an increase in the number of measure eligible hospitals and CAHs are required to report from 2 to 4 (86 FR 45515). We also increased our burden estimate from 1 minute to 2 minutes annually to report 4 measures. In the FY 2023 IPPS/LTCH PPS final rule, we added the AUR surveillance measure for eligible hospitals and CAHs under this Objective, requiring eligible hospitals and CAHs to attest to active engagement with CDC's National Healthcare Safety Network (NHSN) to submit AUR data and receive a report from NHSN indicating their successful submission of AUR data for the EHR reporting period (87 FR 49394). Also in the FY 2023 IPPS/LTCH PPS final rule, we added a requirement for eligible hospitals and CAHs to submit their level of engagement for the measures under this Objective, either Pre-production and Validation or Validated Data Production (87 FR 49394). The burden associated with the actual submission of AUR data to NHSN is accounted for under OMB control number 0920-0666.

The total annual burden per eligible hospital and CAH for this Objective is estimated to be 3.5 minutes (0.0583 hours). Across all eligible hospitals and CAHs, we estimate a

total annual burden of is 262.5 hours (0.0583 hours x 4,500 hospitals) at a cost of $11,776 (262.5 hours x $44.86).

g. eCQM Measure Reporting and Submission Requirements

In the FY 2023 IPPS/LTCH PPS final rule, we finalized an increase to the total number of eCQMs to be reported from four to six eCQMs beginning with the CY 2024 reporting period. We also finalized that the six eCQMs must be comprised of: (1) Three self-selected eCQMs; (2) the Safe Use of Opioids—Concurrent Prescribing eCQM; (3) the Severe Obstetric Complications eCQM; and (4) the Cesarean Birth eCQM, for a total of six eCQMs. In the FY 2024 IPPS/LTCH PPS final rule, we finalized our proposal to adopt three eCQMs beginning with the CY 2025 reporting period: (1) Hospital Harm – Pressure Injury eCQM; (2) Hospital Harm – Acute Kidney Injury eCQM; and (3) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults eCQM. While this results in new eCQMs being added to the measure set, eligible hospitals and CAHs would not be required to report more than a total of six eCQMs for the CY 2024 reporting period and subsequent years.

We continue to estimate the information collection burden associated with the eCQM reporting and submission requirements to be 10 minutes per measure per quarter. The burden associated with the reporting of eCQM measures for 3,150 eligible hospitals and 1,350 CAHs as part of the Hospital Inpatient Quality Reporting Program is included under OMB control number 0938-1022 (CAHs are referred to as non-IPPS hospitals under OMB 0938-1022).

h. Burden Estimate Summary

As shown in Table 2, we estimate the total annual burden for all participants in the Medicare Promoting Interoperability Program represents a total of approximately 29,625 hours for all eligible hospitals and CAHs (6.583 hours x 4,500 eligible hospitals and CAHs) at a total cost of $1,328,978 (29,625 hours x $44.86). This is an increase of 37.5 hours and $1,683 across all eligible hospitals and CAHs.

Table 2. Summary of Annual Burden Estimates for the CY 2023 through CY 2026 EHR Reporting Periods

Objective	CY 2023 EHR Reporting Period	CY 2024-2026 EHR Reporting Periods	Difference From Currently Approved
Protecting Patient Health Information	27,075	27,075	0
Electronic Prescribing	788	788	0
Health Information Exchange	750	750	0
Provider to Patient Exchange	750	750	0
Public Health and Clinician Data Exchange	225	262	+37

Objective	CY 2023 EHR Reporting Period	CY 2024-2026 EHR Reporting Periods	Difference From Currently Approved
Total Burden Hour Estimate	**29,588**	**29,625**	**+37**
Total Burden Cost Estimate	**$1,327,295**	**$1,328,978**	**+$1,683**

These burden estimates exclude burden associated with the reporting of electronic clinical quality measures for eligible hospitals under OMB control number 0938-1022, as Medicare hospitals report the data to CMS once per year for credit under both the Hospital Inpatient Quality Reporting Program and the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

13. Capital Costs (Maintenance of Capital Costs)

In order to attest to the Antimicrobial Use and Resistance (AUR) Surveillance measure successfully, an eligible hospital or CAH must be in active engagement with CDC's NHSN to submit AUR data and receive a report from NHSN indicating their successful submission of AUR data for the EHR reporting period. Participation in NHSN's surveillance requires the purchase or building of an AUR reporting solution. While thousands of hospitals have voluntarily done this to date, for hospitals that have not yet implemented an AUR reporting solution, we estimate the cost to range between $17,000 and $388,500 annually, with a median of $187,400[1]. We believe these associated costs are outweighed by the more than $4.6 billion in health care costs spent annually treating antibiotic resistance threats[2].

In the FY 2024 IPPS/LTCH PPS final rule, we finalized our proposal to modify the SAFER Guides measure to require eligible hospitals and CAHs to submit a "yes" attestation to fulfill the measure beginning with the EHR reporting period in CY 2024. In the CY 2022 IPPS/LTCH PPS final rule, we adopted the SAFER Guides measure and required eligible hospitals and CAHs to attest "yes" or "no" as to whether they completed an annual self-assessment on each of the nine SAFER Guides during the calendar year in which their EHR reporting period occurs (86 FR 45479 through 45481). Given that this proposal was finalized, eligible hospitals and CAHs are required to complete an annual self-assessment on each of the nine SAFER Guides. Because each eligible hospital and CAH is unique and may conduct these self-assessments with varying degrees of rigor, we are unable to accurately estimate the time each eligible hospital or CAH would spend performing each self-assessment or the staff they would utilize. Therefore, we estimate the time required to conduct each self-assessment would range from approximately 30 minutes per guide to approximately 20 minutes per recommendation.[3] Across the nine SAFER Guides and 165 recommendations within them, the estimated time to complete all nine self-assessments would range from a minimum of 4.5 hours to a maximum of 55 hours. Based on the suggested sources of input provided in the SAFER Guides, we assume that eligible

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5051263/

[2] https://www.cdc.gov/drugresistance/solutions-initiative/stories/partnership-estimates-healthcare-cost.html

[3] Toward More Proactive Approaches to Safety in the Electronic Health Record Era. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8136246/. Accessed December 14, 2022.

hospitals and CAHs will form multi-disciplinary teams composed of 1.0 FTE of a clinical administrator and 0.75 FTE each of a clinician, support staff, EHR developer, and health IT support staff to conduct the self-assessments. Table 3 provides the detail of our calculated cost to conduct SAFER Guide self-assessments.

Table 3. Cost Per Eligible Hospital and CAH to Conduct SAFER Guides Self-Assessment

Eligible Hospital/CAH Staff Title	BLS Labor Category (Occupation Code)[4]	Wage Rate*	FTE	Labor Cost
Clinicians	Physicians	$242.76	0.75	$182.07
Support Staff	Medical Record Specialists	$44.86	0.75	$33.65
Clinical Administration	Medical and Health Services Managers	$97.44	1.0	$97.44
EHR Developer	Web Developers	$116.10	0.75	$87.08
Health IT Support Staff	Health Information Technologists and Medical Registrars	$53.42	0.75	$40.07
Total Cost Per Hour of Self-Assessment Team				$440.31
Minimum Cost to Conduct Self-Assessment (4.5 hours x $440.31/hour)				**$1,981**
Maximum Cost to Conduct Self-Assessment (55 hours x $440.31/hour)				**$24,217**

* We calculated the cost of overhead, including fringe benefits, at 100 percent of the median hourly wage. This is necessarily 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 total cost is a reasonably accurate estimation method.

Using the cost to complete all nine self-assessments from Table 3, we estimate all 4,500 eligible hospitals and CAHs would require between 20,250 hours (4.5 hours per hospital/CAHs x 4,500 hospitals/CAHs) and 247,500 hours (55 hours per hospital/CAHs x 4,500 hospitals/CAHs) at a cost between $8,916,278 (20,250 hours x $440.31/hour) and $108,976,725 (247,500 hours x $440.31/hour) in order to attest "yes" to the measure.

While the cost to conduct a SAFER Guides self-assessment can be high, we believe the cost is outweighed by the potential for improved healthcare outcomes, increased efficiency, reduced risk of data breaches and ransomware attacks, and decreased malpractice premiums[5].

14. Cost to the Federal Government

To collect the required information, the cost to the Federal Government (CMS) includes costs associated with 3 CMS staff at a GS-13 level with approximate salaries of $112,015 per staff member to operate, for a cost of $336,045. While the Medicare Promoting Interoperability Program will not have contractual support for data validation until CY2024, as these data will be collected in a system that is currently operating to support different hospital quality reporting programs, this contractual support is estimated at $10,050,000, which is in alignment with the other hospital quality reporting programs. We note that we are currently collecting these data with the Hospital Quality Reporting (HQR) system.

[4] https://www.bls.gov/oes/current/oes_nat.htm. Accessed December 14, 2022.
[5] https://www.eisneramper.com/safer-guides-healthcare-organizations-0822/. Accessed December 14, 2022.

15. Program or Burden Changes

Due to revisions to burden estimates associated with optional reporting of bonus measures under Public Health and Clinical Data Exchange Objective, we are estimating an increase of 37.5 hours and $1,682 across all eligible hospitals and CAHs under OMB control number 0938-1278. The updated wage rate from $42.40 to $44.86 results in an additional cost of $72,785 (29,588 hours x $2.46 per hour).

16. Publication and Tabulation Dates

Information will be viewable on the Care Compare website and the Medicare Promoting Interoperability Program website[6]. Information for public viewing available on the Medicare Promoting Interoperability Program page is geared toward educational and contextual assistance for those learning about the program including but not limited to: latest news, dates to remember, program requirements, contact information, as well as useful links to the Federal Register, FAQ, and objective-measure specification sheets. Information for public viewing available on the Care Compare website is geared toward public posting of overall scoring and performance data on eligible hospitals and CAHs.

17. Expiration Date

There are no additional forms associated with this information collection request besides the online form used for submitting attestations. We plan to post the PRA disclosure statement including the expiration date on the cms.gov website, https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

The use of statistical methods does not apply to this form.

[6] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html