Supporting Statement – Part A
New Procedural Requirements for the FY2014 Inpatient Psychiatric Facility Quality Reporting Program (IPFQR Program)

A. Background

Pursuant to section 1886(s)(4) of the Social Security Act, as amended by sections 3401 and 10322 of the Affordable Care Act, starting in FY 2014, and for subsequent fiscal years, inpatient psychiatric facilities (IPF) shall submit pre-defined quality measures to CMS. Those IPFs failing to report on the selected quality measures will have their IPF PPS payment updates reduced by 2.0 percentage points. To comply with the statutory mandate, we are creating the Inpatient Psychiatric Quality Reporting (IPFQR) Program.

For the FY 2014 IPFQR Program payment determination, we are proposing six (6) National Quality Forum (NQF) endorsed process measures developed by The Joint Commission (TJC). In selecting the proposed quality measures, we strive to achieve several objectives. First, the measures should relate to the general aims of better care, better health, and lower cost. Second, the measures should be tailored to the needs of improved quality in the inpatient psychiatric settings; thus, the measures selected are most relevant to IPFs. Finally, the measures should be minimally burdensome to IPFs.

MEASURE ID	MEASURE DESCRIPTION
HBIPS-2	Hours of Physical Restraint Use NQF #0640)
HBIPS-3	Hours of Seclusion Use (NQF #0641)
HBIPS-4	Patients Discharged on Multiple Antipsychotic Medications (NQF #0552)
HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (NQF #0560)
HBIPS-6	Post Discharge Continuing Care Plan Created (NQF #0557)
HBIPS-7	Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge (NQF #0558)

Although IPFs have not reported on quality measures to CMS, they have some familiarity with and experience in reporting of quality data to other entities such as TJC, National Committee for Quality Assurance (NCQA), Center for Quality Assessment and Improvement in Mental Health (CQIMH) and the Agency for Healthcare Research and Quality (AHRQ).

Any quality reporting program will impose certain data collection and reporting requirements on participating facilities, however, the proposed measures minimize the collection and reporting burden on IPFs because the proposed IPFQR Program measures cover processes that IPFs are currently recording as conditions of Medicare participation. The proposed measures will help achieve our aims of better care, better health, and lower cost while keeping the burden imposed on IPFs at a minimum.

B. Justification

1. Need and Legal Basis

Section 1886(s)(4)(C) of the Act requires that, for FY 2014 (October 1, 2013 through September 30, 2014) and each subsequent fiscal year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures as specified by the Secretary. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary.

In implementing the IPFQR Program, we believe that the development of a quality reporting program that is successful in promoting the delivery of high quality health care services in IPF setting is of paramount importance. Therefore, in our effort to provide services to the IPFs and implementing the statutorily mandated IPFQR Program, we are proposing some procedural requirements.

Section 1886(s)(4)(E) of the Act requires the Secretary to establish procedures for making public the data submitted by IPFs under the quality reporting program. In order for CMS to publish the measure rates, IPFs would need to submit the Notice of Participation (NOP) form. By such submission, IPFs indicate their agreement to participation in the IPFQR Program and shall submit the required data pertaining to the six (6) quality measures and additionally, consent to publicly report their measure rates on the CMS Web site. We are mindful and respectful that IPFs may choose not to participate or withdraw from the IPFQR Program. To this end, our procedures include the necessary steps IPFs will have to take to indicate their intent.

As part of our procedural requirements, we are also requiring the IPFs to acknowledge the accuracy and completeness of the data submitted. We seek to efficiently collect information on valid, reliable, and relevant measures of quality and to share this information with the public, therefore, IPFs will have to submit the Data Accuracy and Completeness Acknowledgement (DACA) form. Other forms the IPFs may need to submit (depending on their decision to participate or their specific needs) will be the Notice of Participation Form, Decline to Participate Form, Participation Withdrawal Form, Reconsideration Request Form, and Extraordinary Circumstance/Disaster Extension or Waiver Request Form. .

2. Information Users

- IPFs: IPF main focuses are to examine individual PCH's specific care domains and types of patients and can compare present performance to past performance with national performance norms; IPF's use Quality Measures to evaluate the effectiveness of care provided to specific types of patients and, in the context of investigating processes of care, to individual patients; to continuously monitor quality improvement outcomes over time, and to objectively assess their own strengths and weaknesses in the clinical services they provide; and to address the care-related areas, activities, and/or behaviors that result in effective patient care, and alert them to needed improvements. Such information is essential to IPFs in initiating quality improvement strategies. They can also be used to improve IPFs' financial planning and marketing strategies.

- State Agencies/CMS: Agency profiles are used in the process to compare a IPF's results with its peer performance. The availability of peer performance enables state agencies and CMS to identify opportunities for improvement in the IPF, and to evaluate more effectively the IPF's own quality assessment and performance improvement program.

- Accrediting Bodies: National accrediting organizations such as the Joint Commission or state accreditation agencies may wish to use the information to target potential or identified problems during the organization's accreditation review of that facility.

- Beneficiaries/Consumers: Since November 2003, the Hospital Inpatient Quality Reporting (HIQR) Program has been publicly reporting quality measures. The IPFQR program will also be publicly reporting data through the CMS.gov website. This provides information for consumers and their families about the quality of care provided by individual hospital, allowing them to see how well patients of one agency fare compared to other agencies and to the state and national average. The information is presented in consumer-friendly language and provides a tool to assist consumers in the selection of a hospital.

The information submitted related to the six proposed measures listed in the table above will be used by CMS to identify opportunities for improvement in the coordination of care (HBIPS 6&7), safety of healthcare provided (HBIPS 2 through 5), and to effectively target quality improvement initiatives in order to meet the statutory requirements of the Affordable Care Act Sections 3401 and 10322 as mandated for CMS. The information gathered will in turn be made available to IPFs for their use in specifying areas of need for internal quality improvement initiatives.

The HBIPS Measures were chosen as they have been utilized for two years by TJC to evaluate and assess related quality of care in their member IPFs. CMS determined that these same measures and the data collection definitions that have been tested and proven to improve quality of care provided and to identify areas of need for quality of care improvement within all CMS certified IPFs. Documentation on the TJC website provided at the link below provides details to show how the reporting on the measures has brought attention to the actions necessary to improve the care provided related to the measures.
http://www.jointcommission.org/assets/1/6/TJC_Annual_Report_2011_9_13_11_.pdf.

3. Use of Information Technology

IPFs will be able to utilize electronic means to submit/transmit their forms and data via a CMS provided secure data warehouse which will be available on the QualityNet (QNet) Exchange website. IPF users will be required to open an account to set up secure logins and then will be able to complete all the necessary forms as may be applicable to circumstance (i.e. NOP, DACA, Request for Reconsideration, etc). We have included copies of these forms with this package. A Web-based Measure online tool will be used for data entry through the QualityNet Exchange website. Data will be stored to support on-line reports views to be available for hospitals to preview their measure rates/results prior to release of data to on the CMS website for public viewing.

4. Duplication of Efforts

Hospitals that are currently collecting and reporting this data to TJC can use the same information to report to CMS which avoids duplication of efforts for them. It will be a new effort for non TJC member hospitals but the opportunity to include these other IPFs in the quality improvement process is seen as highly important to the care of CMS patients and supports the mandates of the ACA.

5. Small Business

Information collection requirements were designed to allow maximum flexibility specifically to small hospitals or IPF providers wishing to participate in hospital reporting. This effort will

assist small hospitals or IPF providers in gathering information for their own quality improvement efforts. For example, we will be providing a help-desk hotline for troubleshooting purposes and 24/7 free information available on the QualityNet Web site.

6. Less Frequent Collection

We have designed the collection of quality of care data to be the minimum necessary for reporting of psychiatric data on measures considered to be meaningful indicators of psychiatric patient care by the National Quality Forum. To this end, we are requiring yearly data submission.

7. Special Circumstances

Although IPF participation is voluntary, all eligible IPFs must submit their data in order to receive the full market basket update for a given fiscal year.

8. Federal Register Notice/Outside Consultation

CMS is supported in this initiative by TJC, National Quality Forum (NQF), and the Agency for Healthcare Research and Quality (AHRQ). These organizations, in conjunction with CMS, will provide technical assistance in developing and/or identifying quality measures, and assist in making the information accessible, understandable, and relevant to the public.

A 60-day Federal Register Notice was included as part of the proposed regulation that displayed on April 24, 2012.

9. Payment/Gift to Respondent

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

10. Confidentiality

All information collected under this initiative will be maintained in strict accordance with statutes and regulations governing confidentiality requirements which can be found at 42 CFR Part 480. In addition, the tools used for transmission of data are considered confidential forms of communication and are HIPAA compliant. The clinical warehouse also voluntarily meets or exceeds the HIPAA standards (please see the attached HIPAA compliance summary).

11. Sensitive Questions

No case specific clinical data elements will be collected for the IPFQR Program. Pursuant to 42 CFR Part 480, no case specific clinical data will be collected or released to the public.

12. Burden Estimate (Total Hours & Wages)

Historically, IPFs have not been required to report quality data to CMS. However, they have been required to report quality measures to other entities such as TJC or state survey and other certification organizations. Therefore, although IPFs have not reported on quality measures to CMS, they have some familiarity with and experience in reporting of quality data. In our burden calculation, we have included the time used for chart abstraction and for training

personnel on collection of chart-abstracted data, aggregation of the data, as well as training for submitting the aggregate-level data through QualityNet.

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The burden estimates for data collection related to the proposed measures for the IPFQR Program are calculated for the IPFs with the following figures. There are approximately 471,811 inpatient psychiatric cases for all facilities annually and there are approximately 1,741 IPF facilities nationwide. There is an average of 271 Inpatient Psychiatric (IPF) Cases per Facility annually, or an average of 23 inpatient psychiatric cases in a given month. The average time spent per each psychiatric measure per patient chart abstraction is approximately 30 minutes (based on 2007 GAO measure abstraction work effort survey GAO-07-320). This includes an estimate of approximately 25 minutes of clinical time spent to conduct chart abstraction for each measure and approximately 5 minutes of administrative time spent to submit data from each psychiatric measure to CMS through the online data entry tool. To report on all six IPF measures for chart abstraction and administrative time totals approximately 3 hours. Thus, with 471,811 cases this creates an annual burden of 1,415,433 annual burden hours for all facilities (See Table A).

Table A

Number of IPFs	**Number of Cases per IPF**	**Total Number of Cases**	**Burden Hours**	**Annual Burden Hours**
1741	271	471,811	3	1,415,433

The PRA costs related to wages is based on the Bureau of Labor Statistics (BLS)[1] wage estimates for healthcare workers that are known to engage in chart abstraction (e.g., $29.47/hour). This calculated for the 813 hours for chart abstraction and data submission is $23,959.11 annual cost per each facility. The estimated burden for training personnel for data collection and submission for HBIPS measures is 8 hours per facility or 13,928 hours for all 1,741 IPFs. The cost for this training based on an hourly rate of $29.47 is $235.76 training costs for each IPF and $410,458.16 training costs for all IPFs annually. The total burden estimates for all data collection and submission costs for each facility is $41,712,810.51 annually. The total annual cost for all the facilities for training is $410,458.16 and all-inclusive total of $42,123,268.67 (See Table B).

Table B

Tasks	**Hours per IPF**	**Wage rate**	**Cost per IPF**	**Total cost for all IPFs**
Data Collection and Submission	813	$29.47	$23,959.11	$41,712,810.51
Training	8	$29.47	$235.76	$410,458.16
Total				$42,123,268.67

[1] BLS May 2010 National Occupational Employment and Wage Estimates - United States

http://www.bls.gov/oes/current/oes_nat.htm#31-0000

The Notice of Participation and the Data Accuracy and Completeness Acknowledgment forms are required to be filled out only once for each overall data submission. All others are optional. It is estimated that these should take less than five minutes to complete thus the burden related to this activity is negligible.

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs being placed on IPFs.

14. Cost to Federal Government

The data for the IPFQR Program measures will be reported directly to QualityNet Exchange website utilizing existing system functionality and support. A support contractor will be utilized to provide help desk and Q&A assistance as well as the monitoring and evaluation effort for the program. There is minimal time that will be required of the program COR to provide oversight and management of efforts. There will be minimal additional costs for development of the data entry tools as describe earlier .

The labor cost for IPFQR program oversight estimated as follows:

- first year 1.0 FTE (2080 hours) at GS-12 salary = $83,200
- for subsequent years .25 FTE(520 hours)at GS-12 salary = $20,800

15. Program or Burden Changes

Between the draft rule and the final rule, there have been minor editorial changes to the forms. The burden has not changed.

16. Publication/Tabulation Dates

CMS will not be employing any sampling techniques or statistical methods. CMS is not the measure steward and does not have ownership to the measure specifications. However, IPFs will have to comply with the measure specifications (including sampling and validation techniques) set forth by TJC.

IPFs will submit their measures through a web-based measures tool on QualityNet. After IPFs have previewed their data and agree to publicly report their measure rates, CMS will publicly display the measure rates on the CMS Web site. The following is the planned schedule of activities to reach these objectives.

ACA 10322

04/13/2012	Proposed Rule Published
08/02/2012	Final Rule Published
10/01/2012	Measures Publicly Announced
10/01/2012	Start of Reporting Period
01/01/2013	Notice of Participation Begins
03/31/2013	End of Reporting Period
07/01/2013	Begin Data Entry
08/15/2013	Deadline to Submit Notice of Participation
08/15/2013	Deadline to Complete Data Accuracy Completion Agreement (DACA)
01/01/2014	Public Posting on CMS.gov

17. Expiration Date

We request an exemption from displaying the expiration date because these tools will be used on a continuous basis by hospitals reporting quality data.