Supporting Statement – Part A

New Procedural Requirements for the FY 2016 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 the Centers for Medicare & Medicaid Services (CMS). The IPFs that fail 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 updating the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program for FY 2016.

For the FY 2016 IPFQR Program, we will continue to collect the six (6) National Quality Forum (NQF)-endorsed process measures developed by The Joint Commission (TJC) that were used in reporting Fiscal Years 2014 and 2015 (listed below). We also intend to collect three (3) additional NQF reviewed process measures and propose voluntary submission of data on a fourth measure. These measures are listed below.

Current Measure Set

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)

New Proposed Measure Set

Measure Type	Measure and NQF Status	Measure Title
Process	0576 Endorsed	Follow-up After Hospitalization for Mental Illness
Process	M2753 Not Endorsed	SUB-1 Alcohol Use Screening
Process	M2754 Not Endorsed	SUB-4 Alcohol & Drug Use: Assessing Status After Discharge

The voluntary submission measure is a yes/no statement regarding the use of a standardized instrument to assess the patient experience of care. This measure will not impact a facility's FY2016 payment determination. Due to an interest in collecting this information, it has been included in the burden calculation.

In selecting the proposed quality measures, we strive to achieve several objectives. First, the measures should relate to the National Quality Strategy aims of better care, healthy populations and communities, and affordable care. Second, the measures should be tailored to the needs of improved quality in the inpatient psychiatric setting; thus, the measures selected are most relevant to IPFs. Finally, the measures should be minimally burdensome to the IPFs.

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 the 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 participate in the IPFQR Program and that they shall submit the required data pertaining to the ten (10) quality measures and additionally, consent to publicly report their measure rates on a CMS website. We are mindful and respectful that IPFs may choose not to participate or may choose to 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 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**: The IPF main focus is to examine individual IPFs' specific care domains and types of patients and compare present performance to past performance and to national performance norms; IPFs 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 themselves to needed improvements. Such information is essential to IPFs in initiating quality improvement strategies. This information can also be used to improve IPFs' financial planning and marketing strategies.

- **State Agencies/CMS**: Agency profiles are used in the process of comparing an 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 (TJC) 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 a CMS.gov website. This provides information for consumers and their families about the quality of care provided by individual hospitals, allowing them to see how well patients of one facility fare compared to other facilities 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.

CMS will use the information submitted related to the 10 proposed measures listed in the tables above to identify opportunities for improvement in the coordination of care and to effectively target quality improvement initiatives to meet the statutory requirements of the Affordable Care Act Sections 3401 and 10322 as mandated for the agency. 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 because TJC has utilized them for three years 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 are valuable within all CMS-certified IPFs. Documentation on the TJC website provided at the link below provides details to show how reporting on these 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.

One priority area currently unaddressed in the IPFQR Program is that of patient and family engagement and experience of care. On the "List of Measures Under Consideration for December 1, 2012," CMS included NQF #0726, "Inpatient Consumer Survey of Inpatient Behavioral Healthcare Services" (ICS). The MAP provided input on this measure supporting its inclusion in the IPFQR Program. Although this specific measure is endorsed by NQF, CMS is recommending, in the short term, to propose a structural measure of whether the facility assesses patient experience of inpatient behavioral health services using a standardized instrument. This

will be collected through the Web-Based collection tool as a yes/no question; facilities that answer "Yes" will be asked to indicate the name of the survey that they administer.

The "Follow-up After Hospitalization for Mental Illness" (Measure 0576) was identified as a high-impact measure for improving care for the vulnerable dual eligible population. This NQF-endorsed measure addresses several principles of the National Quality Strategy (NQS) while focusing on the person-centered episode of care. Information regarding this measure, including evidence of its impact, can be found at the link below.
http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70617

The SUB-1 and SUB-4 measures are specified by TJC to evaluate and assess quality of care for inpatient hospitals. CMS has determined that these measures relate to important aspects of the NQS that have not been covered by the existing measure set, and that these measures will help to improve quality of care and the patient-centered aspect of care across multiple settings. Documentation on the TJC website provided at the link below provides details on the specification of these measures.
http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx.

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 web-based tool, which will be available on the QualityNet (QNet) 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/applications as may be applicable to their circumstance (i.e., NOP, DACA, Request for Reconsideration, etc.). We have included copies of these forms within this package.

A Web-based Measure online tool will be used for data entry through the QualityNet website. Data will be stored to support retrieving reports for hospitals to view their measure rates/results. Hospitals will be sent a preview report via QualityNet Exchange 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 and reduces burden to the IPFs. It will be a new effort for non-TJC member IPFs, but the opportunity to include these other IPFs in the quality improvement process is seen as highly important to the quality of care for CMS patients and supports the mandates of the ACA.

5. Small Business

Information collection requirements were designed to allow maximum flexibility specifically to small IPF providers participating in the IPFQR program. This effort will assist small 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 website through a Questions and Answers (Q&A) functionality.

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 to receive the full market basket update for a given fiscal year. If data is not submitted to CMS, the IPF will receive a reduction of 2 percentage points from their Annual Payment Update (APU).

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 will be included as part of the proposed regulation that is expected to be displayed in April 2013.

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.

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 and Wages)

Until FY 2014, IPFs had 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 had 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. Because IPFs have been submitting 6 of the 10 measures to CMS, the amount of training required to submit data should be reduced to training for facilities new to the program and training on the collection of data and submission only for the four new measures.

The burden estimates for data collection related to the proposed measures for the IPFQR Program are calculated for the IPFs based on the following data:

- There are approximately 2,200 IPF facilities nationwide (based on the total number of facilities as of January 2013).
- The average IPF facility handles 271 cases per year (based on total claims and number of facilities from the last data available).
- The average IPF facility handles approximately 68 cases per quarter.
- 2,200 IPF facilities, with approximately 271 cases per facility, results in a total of 596,200 cases per year.
- The average time spent per each psychiatric measure per patient chart abstraction is approximately one half of an hour (based on 2007 GAO measure abstraction work effort survey – GAO-07-320).
- The time spent for abstracting each measure is 30 minutes per case (including 25 minutes of clinical time and five minutes of administrative time submitting the data).
- The total number of cases to be submitted for each measure varies based on measure-specific sampling criteria (see Table A).

Table A

NQF Number	Measure ID	Measure Description	Annual Sampling Rate	Effort per Case	Annual Effort per Facility
0640	HBIPS-2	Hours of Physical Restraint Use	All Patients (271/facility)	½ hour	135.5 hours
0641	HBIPS-3	Hours of Seclusion Use	All Patients (271/facility)	½ hour	135.5 hours
0552	HBIPS-4	Patients Discharged on Multiple Antipsychotic Medications	176/facility[1]	½ hour	88 hours
0560	HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	176/facility	½ hour	88 hours
0557	HBIPS-6	Post-Discharge Continuing Care Plan Created	176/facility	½ hour	88 hours

[1] Measure specifications indicate that for quarterly population between 44 and 220, a minimum of 44 cases must be abstracted, yielding 176 cases per year for NQF 0552, 0560, 0557, and 0558.

NQF Number	Measure ID	Measure Description	Annual Sampling Rate	Effort per Case	Annual Effort per Facility
0558	HBIPS-6	Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	176/facility	½ hour	88 hours
N/A	SUB-1	Alcohol Use Screening	271/facility[2]	½ hour	135.5 hours
N/A	SUB-2	Alcohol & Drug Use Assessing Status After Discharge	271/facility	½ hour	135.5 hours
0576	FUH	Follow-Up After Hospitalization for Mental Illness	271/facility[3]	½ hour	135.5 hours
N/A	N/A	New Voluntary Structural Measure – Facility Assessment of Patient Experience of Care	Annual Acknowledgement Only	½ hour	½ hour
				Annual Total	**1,030 hours/facility**

The Paperwork Reduction Act costs related to wages is based on the Bureau of Labor Statistics (BLS)[4] wage estimates for healthcare workers that are known to engage in chart abstraction (e.g., $31.71/hour). This calculated for the 1,030 hours for chart abstraction, and data submission is $32,661.30 annual cost for each facility. The total annual cost for all IPFs is $71,854,860. The estimated burden for training personnel for data collection and submission for current and future measures is 6 hours per facility. (This is reduced from the previous years because the majority of participating facilities will have been trained for prior years and will only need to be trained for new measures and associated reporting.) The cost for this training, based on an hourly rate of $31.71, is $190.26 training costs for each IPF, which totals $418,572 for all facilities. The all-inclusive program total for each facility is $32,851.56, and for all facilities it is $72,273,532 (See Table B).

Table B

Tasks	Hours per IPF	Total Hours for All IPFs	Wage Rate	Cost per IPF	Total Cost for All IPFs
Chart-Abstracted Measure Data Collection and Submission	1030	2,266,000	$31.71	$32,661.30	$71,854,860
Training	6	13,200	$31.71	$190.26	$418,572
Totals	**1036**	**2,279,200**		**$32,851.56**	**$72,273,432**

[2] Average caseload of 271 patients per year is below the threshold for sampling for SUB-1 and SUB-2.
[3] Sampling is not consistent with using this measure at the facility level.
[4] BLS May 2010 National Occupational Employment and Wage Estimates - United States http://www.bls.gov/oes/current/oes_nat.htm#31-0000

The NoP and the DACA forms are required to be filled out only once for each data submission period. All others forms are optional. It is estimated that these forms should take less than five minutes to complete, thus the burden related to this activity is negligible.

Three factors increase the burden in comparison to the burden calculation previously submitted. These factors are the impact in number of measures to, the increase in salary rates over prior years, and a decrease in the average amount of training required for each participating facility. This yields an overall increase in burden of 215 hours and $8,366.13 dollars per facility. (See Table C)

Table C

	Total Hours per IPF	**Total Cost per IPF**	**Total Program Hours**	**Total Program Cost**
Prior Total Burden	821	$24,194.87	1,429,361	$42,123,268.67
New Total Burden	1036	$32,661	2,279,200	$72,273,432
Amount of Increase	215	$8,366.13	849,839	$30,150,163.33

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 the QualityNet website utilizing existing system functionality. 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 will be minimal costs for development of the data entry tools because, as described earlier, the development is part of an existing software development contract.

The labor cost for IPFQR program oversight is estimated as follows:

- Current year 1.0 FTE (2,080 hours) at GS-13 salary = $106,839
- For subsequent years 1.0 FTE (2,080 hours) at GS-13 salary = $106,839

15. Program or Burden Changes

The number of IPF hospitals is constantly changing. As of January 2013, there are approximately 1,900 IPFs that fall under the program. This has been changed in the information under section 12 from 1,741 IPFs.

As shown above, this program has increased the number of measures included in its data collection requirements. The CMS program reduces the reporting burden for quality of care information collected by allowing hospitals to abstract data directly into electronic systems in lieu of submitting paper charts, or to utilize electronic data that they already report to the Joint

Commission (JCO) for accreditation. The long-term vision for the IPFQR program is to allow hospitals to submit data directly from their electronic health records, which we anticipate will reduce burden substantially. The 2012 Electronic Reporting Pilot (76 FR 74490) is an important step in the transition from paper to electronic reporting.

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 of the measure specifications. However, IPFs will have to comply with the measure specifications (including sampling and validation techniques) set forth by measure stewards.

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

Date	Scheduled Activity
4/13/2013	Proposed Rule Published
8/2/2013	Final Rule Published
10/1/2013	Measures Publicly Announced
1/1/2014	Start of Reporting Period
1/1/2014	Notice of Participation Begins
12/31/2014	End of Reporting Period
7/1/2014	Begin Data Submission
8/15/2014	End Submission Deadline
8/15/2014	Deadline to Submit Notice of Participation
8/15/2014	Deadline to Withdraw from the IPFQR Program
8/15/2014	Deadline to Complete Data Accuracy and Completeness Acknowledgement (DACA)
9/20/2014	Beginning of Preview Period for Public Reporting
10/19/2014	End of Preview Period for Public Reporting
QT 1 FY 15	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.