

Supporting Statement – Part A
Revised and New Procedural Requirements for the FY 2015 Inpatient Psychiatric Facility
Quality Reporting (IPFQR) Program
CMS-10432, OCN 0938-1171
Associated Rule: CMS-1606-F, RIN 0938-AS08

Background

Pursuant to section 1886(s)(4) of the Social Security Act, as amended by sections 3401 and 10322 of the Affordable Care Act (ACA), 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). 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 and FY 2017.

For the FY 2016 payment determination and subsequent years, we will continue to collect the 6 National Quality Forum (NQF)-endorsed process measures developed by The Joint Commission (TJC), as well as the Alcohol Use Screening (SUB-1) and Follow-up After Hospitalization for Mental Illness (FUH) measures. The table below summarizes these measures.

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)
SUB-1	Alcohol Use Screening (NQF #1661)
FUH	Follow-up After Hospitalization for Mental Illness (NQF #0576)

For the FY 2016 payment determination and subsequent years, we added the Assessment of Patient Experience of Care, previously included as a voluntary submission, and the Use of an Electronic Health Record measures. The table below summarizes these measures.

New Finalized Measures for FY 2016

Measure Type	Measure and NQF Status	Measure Title
Structural	N/A	Assessment of Patient Experience of Care

Structural	N/A	Use of an Electronic Health Record
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For the FY 2017 payment determination and subsequent years, we added the Influenza Immunization (IMM-2), Influenza Vaccination Coverage Among Healthcare Personnel, Tobacco Use Screening (TOB-1), and Tobacco Use Treatment Provided or Offered (TOB-2) and Tobacco Use Treatment (TOB-2a) measures. The table below summarizes these measures.

New Finalized Measures for FY 2017

Measure Type	Measure and NQF Status	Measure Title
Process	NQF #1659, Not endorsed	Influenza Immunization (IMM-2)
Process	NQF #0431, Not endorsed	Influenza Vaccination Coverage Among Healthcare Personnel
Process	NQF #1651, Endorsed	Tobacco Use Screening (TOB-1)
Process	NQF #1654, Endorsed	Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment (TOB-2, TOB-2a)

In selecting new quality measures, we strive to achieve several objectives. First, the measures should relate to the National Quality Strategy (NQS) 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, so as to be relevant to IPFs. Finally, the measures should be minimally burdensome to the IPFs.

A. 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.

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 are required 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 for the FY 2016 payment determination and fourteen (14) quality measures for the FY 2017 payment determination. In addition, IPFs give their 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 that IPFs have to take to indicate their intent.

As part of our procedural requirements, we require that IPFs acknowledge the accuracy and completeness of submitted data. We seek to collect information on valid, reliable, and relevant measures of quality, and to share this information with the public; therefore, IPFs must submit the Data Accuracy and Completeness Acknowledgement (DACA). IPFs may need to submit the Notice of Participation form, which this year can also be used to indicate an IPF's intent not to participate or withdraw from the Program. In our effort to foster alignment across quality reporting programs, we are removing the Extraordinary Circumstances Exception form and the Reconsideration Request form, and now submitting these forms as part of the Hospital Inpatient Quality Reporting (HIQR) Program's PRA package (OMB control number 0938-1022). While IPFs may also need to complete and submit these forms, the associated burden is addressed in the HIQR PRA package.

2. Information Users

- **IPFs:** The main focus of an IPF is to: examine individual IPFs' specific care domains and types of patients, and compare present performance to past performance and to national performance norms; 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; monitor quality improvement outcomes over time; assess their own strengths and weaknesses in the clinical services that they provide; address care-related areas, activities, 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 website. This provides information for consumers and their families on the quality of care provided by individual hospitals, allowing them to compare patient outcomes between facilities and against the state and national average. The website provides information in consumer-friendly language and offer a tool to assist consumers with selecting a hospital.

CMS use submitted information on the measures listed 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 in turn is 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 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.

The SUB-1 measure is specified by TJC to evaluate and assess quality of care for inpatient hospitals. CMS has determined that this measure relates to important aspects of the NQS that have not been covered by the existing measure set, and that this measure will help to improve quality of care and the patient-centered aspect of care across multiple settings. Documentation on the TJC website at the link below provides details on the specification of this measure.

http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx.

The FUH measure 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 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 Assessment of Patient Experience of Care measure was included on our “List of Measures under Consideration for December 1, 2013.” The Measures Application Partnership (MAP) supported this measure, but encouraged its eventual replacement with a robust survey of patient experience and a measure based on consumer-reported information, such as a CAHPS tool. This measure was chosen because it will begin to provide information on a NQS priority area that is currently unaddressed in the IPFQR program, namely, patient and family engagement and experience of care.

The Use of an Electronic Health Record measure provides important information about an element of IPF service delivery shown to be associated with the delivery of quality care. It also provides useful information to consumers and others in choosing among different facilities. Moreover, this measure supports the exchange of health information across care partners and during transitions of care, which is a priority area for a number of Department of Health & Human Services (HHS) initiatives.

The IMM-2 measure provides information on influenza vaccination in IPFs. Similarly, the Influenza Vaccination Coverage Among Healthcare Personnel measure provides information on influenza vaccination among healthcare personnel (HCP) in IPFs. Improvements in influenza vaccination can reduce unnecessary hospitalizations and secondary complications. Together,

therefore, these measures provide useful information for both IPFs and consumers alike on the quality of care provided in specific facilities.

The TOB-1, and TOB-2 and TOB-2a measures provide information on tobacco use screening, and tobacco use treatment provided or offered and tobacco use treatment, respectively. Tobacco use is an especially important issue for persons with mental illness or substance abuse disorders, and timely tobacco dependence interventions for patients using tobacco can significantly reduce the risk of suffering from tobacco-related disease, as well as provide improved health outcomes for those already suffering from a tobacco-related disease. Inclusion of these measures encourages the uptake of tobacco cessation treatment and its attendant benefits, while also affording consumers and others useful information in choosing among different facilities.

3. Use of Information Technology

IPFs are 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 are 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 (e.g., NOP, DACA, Request for Reconsideration). We have included copies of these forms within this package.

A Web-based Measure online tool is used for data entry through the QualityNet website. Data are stored to support retrieving reports for hospitals to view their measure rates/results. Facilities are sent a preview report via QualityNet Exchange prior to release of data on the CMS website for public viewing.

4. Duplication of Efforts

Hospitals that currently collect and report this data to TJC can use the same information to report to CMS, which avoids duplication of efforts and reduces burden to the IPFs. As for collection of the FUH measure, CMS will collect such data using Medicare Part A and Part B claims; therefore, it will have no burden on IPFs.

5. Small Business

Information collection requirements are designed to allow maximum flexibility specifically to small IPF providers participating in the IPFQR program. This effort assists small IPF providers in gathering information for their own quality improvement efforts. For example, we provide 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 NQF. To this end, we require 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 are not submitted to CMS, the IPF receives a reduction of 2 percentage points from their Annual Payment Update (APU).

8. Federal Register Notice/Outside Consultation

The proposed rule, serving as the 60-day Federal Register notice, published on May 6, 2014 (79 FR 26040). No comments were received.

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

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 is 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 Health Insurance Portability and Accountability Act (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)

In our burden calculation, we have included the time used for chart abstraction and for training personnel on collection of chart-abstracted data and aggregation of the data, as well as training for submitting aggregate-level data through QualityNet.

Beginning in FY 2016, participating IPFs will need to submit data on 10 measures. Because IPFs have been submitting 8 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 2 new measures. CMS has not included the FUH measure in the measures' burden calculation because, as noted, CMS will gather information on this measure using Medicare Part A and Part B claims data.

Beginning in FY 2017, participating IPFs will need to submit data on 14 measures. Because IPFs have been submitting 10 of the 14 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 4 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:

- We estimate that there will be approximately 574 fewer IPF facilities (or 1,626 facilities) nationwide eligible to participate in the IPFQR Program.
- We estimate that the average facility submits measure data on 556 cases per year (previously 271 cases per year).
- 1,626 IPF facilities, with approximately 556 cases per facility, results in a total of 904,056 cases per year.
- We estimate that it takes an IPF approximately 15 minutes for chart abstraction of a measure for collection.
- In the FY 2014 final rule (78 FR 50964), we estimated that the annual hourly burden per IPF for the collection, submission, and training of personnel for submitting previously adopted quality measures was approximately 761 hours.

Table A – Estimated Annual Effort Per Facility for Newly Adopted Measures

NQF Number	Measure ID	Measure Description	Estimated Cases (per facility)	Effort per Case	Annual Effort (per facility)
N/A	N/A	Assessment of Patient Experience of Care*	0	¼ hour	0
N/A	N/A	Use of an Electronic Health Record*	0	¼ hour	0
1659	IMM-2	Influenza Immunization**	556	¼ hour	139 hours
0431	N/A	Influenza Vaccination Coverage Among Healthcare Personnel**	40	¼ hour	10
1651	TOB-1	Tobacco Use Screening**	556	¼ hour	139 hours
1654	TOB-2, TOB-2a	Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment**	556	¼ hour	139 hours

NQF Number	Measure ID	Measure Description	Estimated Cases (per facility)	Effort per Case	Annual Effort (per facility)
				Annual Total	427 hours/facility

* For the FY 2016 payment determination and subsequent years

** For the FY 2017 payment determination and subsequent years

The Bureau of Labor Statistics wage estimate for health care workers that are known to engage in chart abstraction is \$31.71/hour. To account for overhead and fringe benefits, we have doubled this estimate to \$63.42/hour. This calculated for the 1,188 hours annual effort per facility for the FY 2017 payment determination and subsequent years results in an annual cost per facility of approximately \$75,343. Across all 1,626 IPFs nationwide, this totals \$122,507,653.

The estimated burden for training personnel for data collection and submission for current and future measures is 2 hours per facility. The cost for this training, based on an hourly rate of \$63.42, is \$127 training costs for each IPF, which totals \$206,242 for all facilities.

For the FY 2017 payment determination, IPFs must submit to CMS aggregate population counts for Medicare and non-Medicare discharges by age group, diagnostic group, and quarter, and sample size counts for measures for which sampling is performed (as is allowed for in HBIPS-4 through – 7, and SUB-1). The burden associated with submitting this data to CMS is the time and effort necessary to gather and submit this data to a CMS contractor. We estimate that it will take each facility approximately 2.5 hours to comply with this requirement. This burden across all 1,626 IPFs calculates to 4,065 hours annually at a total of \$257,802 or \$159 per IPF. (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	1,188 (761 + 427)	1,931,688	\$63.42	\$75,343	\$122,507,653
Training	2	3,252	\$63.42	\$127	\$206,242
Non-measure Data Collection and Submission	2.5	4,065	63.42	\$159	\$257,802
Totals	1,192.5	1,939,005		\$75,629	\$122,971,697

Notice of Participation, Data Accuracy Acknowledgement, and Other Forms

The NoP and the DACA forms must be filled out only once for each data submission period. All others forms are optional. While it is estimated that these forms should take less than 5 minutes to complete, the 15 minutes for chart abstraction also includes the time for completing and submitting any forms related to the measures.

In our effort to foster alignment across quality reporting programs, we are removing the Extraordinary Circumstances Exception form and the Reconsideration Request form, and now submitting these forms as part of the Hospital Inpatient Quality Reporting (HIQR) Program's PRA package (OMB control number 0938-1022). While IPFs may also need to complete and submit these forms, the associated burden is addressed in the HIQR PRA package.

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. For purposes of the FY 2016 and FY 2017 IPFQR Program final rule, there are approximately 1,626 IPFs eligible for the Program.

As shown above, this Program has increased the number of measures included in its data collection requirements. Specifically, for the FY 2016 payment determination and subsequent years, 2 new measures were added, and for the FY 2017 payment determination, 4 new measures were added. This Program reduces the reporting burden for quality of care information collected by allowing hospitals to abstract data directly into electronic systems instead 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 this 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.

In our effort to foster alignment across quality reporting programs, we are removing the Extraordinary Circumstances Exception form and the Reconsideration Request form, and now submitting these forms as part of the Hospital Inpatient Quality Reporting (HIQR) Program's

PRA package (OMB control number 0938-1022). While the currently approved iteration of this IPF package inadvertently excluded the burden for completing these forms, this package, consequently, does not set out any burden changes pertaining to removing either of these forms. Importantly, burden changes would also not apply since the 15 minutes for chart abstraction also includes the time for completing and submitting any forms related to the measures.

For purposes of the FY 2016 and FY 2017 IPFQR Program final rule, we are revising the HBIPS Measure Data Collection form, SUB-1 Measure Data Collection form, Vendor Authorization form, and Data Accuracy Acknowledgement to reflect minor updates. We are also updating the Notice of Participation Agreement such that it now can be used by IPFs to also indicate their intent not to participate or withdraw from the Program. We are in turn removing the previous Decline to Participate form and Participation Withdrawal form from this year's PRA package. Because these changes are minor, we do not anticipate any measureable increase in burden on IPFs associated with these changes. We are also adjusting our burden estimates as follows:

-We estimate that there will be approximately 574 fewer IPF facilities (or 1,626 facilities) nationwide eligible to participate in the IPFQR Program.

-We estimate that the average facility submits measure data on 556 cases per year (previously 271 cases per year).

-1,626 IPF facilities, with approximately 556 cases per facility, results in a total of 904,056 cases per year.

-Beginning in FY 2016, participating IPFs will need to submit data on 10 measures. Because IPFs have been submitting 8 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 2 new measures.

- Beginning in FY 2017, participating IPFs will need to submit data on 14 measures. Because IPFs have been submitting 10 of the 14 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 4 new measures.

-For this year's PRA package, we are adding the Use of an Electronic Health Record and Assessment of Patient Experience of Care form, and the TOB and IMM Data Collection form. We anticipate only a negligible burden on IPFs to complete and submit these forms.

Changes to the Program for the FY 2016 and FY 2017 payment determinations, including more measures on which to report and an increase in the wage rate, leads to an increase in the total Program burden. For the FY 2017 payment determination and subsequent years, hourly burden per IPF increases by 431.5 hours and by 701,619 hours across all IPFs, while total cost per IPF increases by \$27,366 and by \$44,496,677 across all IPFs. (See Table C)

Table C

	Total Hours per IPF	Total Cost per IPF	Total Program Hours	Total Program Cost
Prior Total Burden	761	\$48,263	1,237,386	\$78,475,020
New Total Burden	1,192.5	\$75,629	1,939,005	\$122,971,697
Amount of Increase	431.5	\$27,366	701,619	\$44,496,677

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
5/6/2014	Proposed Rule Published
8/15/2014*	Final Rule Published
10/1/2014	Measures Publicly Announced
1/1/2015	Start of Reporting Period
12/31/2015	End of Reporting Period
7/1/2016	Begin Data Submission
8/15/2016	End Submission Deadline
8/15/2015	Deadline to Complete Data Accuracy and Completeness Acknowledgement (DACA)
April 2016 (for FY Payment Determination)	Public Posting on CMS.gov. We will allow for a 30 day preview period approximately twelve weeks prior to the public display of data.

*Indicates an approximate estimated date

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.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

Not applicable to this collection.