Supporting Statement – Part A
Revised and New Procedural Requirements for the FY 2016 Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
CMS-10432, OCN 0938-1171

This package is associated with the May 1, 2015, NPRM: CMS-1627-P, RIN 0938-AS47.

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 fiscal year (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 and comply with other administrative requirements will have their IPF prospective payment system (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 2017 and FY 2018.

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, the thirteen (13) quality measures for the FY 2017 payment determination, and the sixteen (16) measures for the FY 2018 payment determination. In additional, 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 removed the Extraordinary Circumstances Exception form and the

Reconsideration Request form and are 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**: The IPFQR Program publicly reports data through a CMS website. This data provides information for consumers and their families on the quality of care provided by individual facilities, allowing them to compare patient outcomes between facilities and against the state and national average. The website provides information in consumer-friendly language and offers a tool to assist consumers with selecting a hospital.

CMS uses the information submitted 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 and SUB-2 and SUB-2a 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, 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 chosen because it will begin to provide information on a NQS priority area that was 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, TOB-2 and TOB-2a, and TOB-3 and TOB-3a measures provide information on tobacco use screening, and tobacco use treatment provided or offered and tobacco use treatment, including at discharge. 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.

The Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) measure seeks to overcome gaps in care transitions caused by inadequate information that lead to avoidable adverse events and cost CMS approximately $15 billion due to avoidable patient readmissions. Public reporting of this measure would afford consumers and their families or caregivers useful information in choosing among different facilities and would promote our National Quality Strategy priority of Communication and Care Coordination. More information on this measure can be found at http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI.

The Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) measure narrows gaps in care transitions that result in adverse health outcomes for patients and about $15 billion in medical costs to CMS due to readmissions. Public reporting of this measure will afford consumers, and their families or caregivers, useful information in choosing among different facilities because it communicates how quickly the a summary of the patient's record will be transmitted to his or her other treating facilities and physicians, improving care, as outlined above. This measure will also promote our National Quality Strategy priority of Communication and Care Coordination. More information on this measure can be found at http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI.

The Screening for Metabolic Disorders measure requires screening for patients on antipsychotics. Antipsychotics have been shown to be related to metabolic syndrome, and this measure seeks to reduce risk that is caused by the delivery of healthcare. This measure promotes the NQS priority of Making Care Safer, which seeks to reduce risk that is caused by the delivery of healthcare

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 is available on the QualityNet 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

Facilities that currently collect and report 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) unless CMS grants an exception or exemption.

8. Federal Register Notice/Outside Consultation

The May 1, 2015 (80 FR 25012), proposed rule is serving as the 60-day Federal Register notice. The rule was placed on file for public inspection on April 24, 2015. Comments are due 60-days later, on June 23.

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.

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 nine (9) fewer IPF facilities (or 1,617 facilities) nationwide eligible to participate in the IPFQR Program.
- We estimate that the average facility submits measure data on 125 fewer cases per year (or 431 cases per year).
- 1,617 IPF facilities, with approximately 431 cases per facility, results in a total of 696,927 cases per year.
- We estimate that it takes an IPF approximately 3 fewer minutes (or 12 minutes) for chart abstraction of a measure for collection based on new reporting requirements.
- We estimate an hourly labor cost of $22.37 (previously $63.42).

For the FY 2017 payment determination and subsequent years, we had adopted fourteen (14) 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-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (NQF #0560)
HBIPS-4	Patients Discharged on Multiple Antipsychotic Medications (NQF #0648)
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)
TOB-1	Tobacco Use Screening (NQF #1651)
TOB-2 TOB-2a	Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment (NQF #1654)
IMM-2	Influenza Immunization (NQF #1659)
N/A	Influenza Vaccination Coverage Among Healthcare Personnel

Measure ID	Measure Description
N/A	Assessment of Patient Experience of Care
N/A	Use of an Electronic Health Record

We are removing one of these measures, HBIPS-4, beginning with the FY 2017 payment determination. The table below summarizes this change.

Measure Removed for FY 2017 and Subsequent Years

Measure ID	Measure Description
HBIPS-4	Patients Discharged on Multiple Antipsychotic Medications (NQF #0648)

Beginning in FY 2018, participating IPFs will need to submit data on sixteen (16) measures. Because IPFs have been submitting eleven (11) of the sixteen (16) 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 five (5) new measures.

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)
1656	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge	431	0.2	86.2
1663	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered	431	0.2	86.2
647	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	431	0.2	86.2

NQF Number	Measure ID	Measure Description	Estimated Cases (per facility)	Effort per Case	Annual Effort (per facility)
648	N/A	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	431	0.2	86.2
N/A	N/A	Screening for Metabolic Disorders	431	0.2	86.2
				Annual Total	**431**

Table B – Estimated Reduction in Annual Effort per Facility for Newly Removed Measures

NQF Number	Measure ID	Measure Description	Estimated Cases (per facility)	Effort per Case	Annual Effort (per facility)
648	HBIPS-4	Patients Discharged on Multiple Antipsychotic Medications (removed for FY 2017 and sub years)	431	0.2	86.2
557	HBIPS-6	Post-Discharge Continuing Care Plan Created(removed for FY 2018 and sub years)	431	0.2	86.2
558	HBIPS-7	Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge (removed for FY 2018 and sub years)	431	0.2	86.2
			Annual Total		**258.6**
			Annual Burden Difference (431-258.6)		**172.4**

We estimate an hourly labor cost of $22.37. This labor cost is based on the Bureau of Labor Statistics (BLS) wage for a Medical Records and Health Information Technician. Additionally, per OMB Circular A-76, in calculating direct labor, agencies should not only include salaries and wages, but also "other entitlements" such as fringe benefits.[1] This Circular provides that the civilian position full fringe benefit cost factor is 36.25 percent. Therefore, we applied an hourly

[1] http://www.whitehouse.gov/omb/circulars_a076_a76_incl_tech_correction.

labor cost of $22.38 ($16.42 base salary + $5.95 fringe) to our burden calculations. This calculated for the 172.4 hours annual effort per facility for the FY 2018 payment determination and subsequent years results in an annual cost per facility of approximately $3,856.59. Across all 1,617 IPFs nationwide, this totals $6,236,102.80.

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 $22.37, is $44.74 for each IPF, which totals $72,344.58 for all facilities.

For the FY 2018 payment determination, IPFs must submit to CMS aggregate population counts for Medicare and non-Medicare discharges by age group, and diagnostic group, and sample size counts for measures for which sampling is performed. Because CMS is eliminating reporting this non-measure data by quarter for all measures and instead will only require this data as an aggregate, annual number, we believe that the addition of five measures leads to a net negligible change in burden associated with non-measure data collection.

Therefore, we estimate a total increase in burden of 174.4 hours per IPF or 282,004.80 hours across all IPFs, resulting in a total increase in financial burden of $3,901.33 per IPF or $6,308,447.38 across all IPFs. (See Table C).

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	172.4	278,770.8	$22.37	$3,856.59	$6,236,102.80
Training	2	3,234	$22.37	$44.74	$72,344.58
Totals	**174.4**	**282,004.8**		**$3,901.33**	**$6,308,447.38**

Table C

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 12 minutes for chart abstraction also includes the time for completing and submitting any forms related to the measures.

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 IPFs is constantly changing. For purposes of the FY 2018 IPFQR Program proposed rule, there are approximately 1,617 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 2018 payment determination and subsequent years, five (5) new measures were added and two (2) were removed. An additional measure was also removed beginning with the FY 2017 payment determination. This Program reduces the reporting burden for quality of care information collected by allowing IPFs 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 (TJC) 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 removed the Extraordinary Circumstances Exception form and the Reconsideration Request form and are now submit these forms as part of the Hospital Inpatient Quality Reporting (HIQR) Program's PRA package (OMB control number 0938-1022).

For purposes of the FY 2018 IPFQR Program proposed rule, we are revising the HBIPS Measure Data Collection form, the SUB-1 Measure Data Collection form, the TOB-1 Measure Data Collection Form, and the IMM-2 Measure Data Collection form to reflect that IPFs no longer need report this measure information by quarter and stratified by age. Instead IPFs must only report this data as one, aggregate, annual count. In addition, we now require aggregate population counts to be reported as a single yearly number rather than by quarter, and we are allowing uniform sampling requirements for certain measures. We believe that these changes will lead to a decrease in burden since facilities would only be required to enter one aggregate number for both the numerator and denominator for each measure and will be allowed to pull one sample for certain measures. Consequently, we believe that the time required to chart-abstract data for these measures would be reduced by 20 percent. Previously, we estimated 15 minutes to chart-abstract data for each case. Because of our proposed changes to sampling and reporting data, we are revising the figure and now estimate 12 minutes (0.20 x 15 minutes), a change of -3 min or -0.05 hr. We are also adjusting our burden estimates as follows:

-We estimate that there will be approximately nine (9) fewer IPF facilities (or 1,617 facilities) nationwide eligible to participate in the IPFQR Program.

- Based on the most recent data, we estimate that the average facility submits measure data on 125 fewer cases per year (or 431 cases per year).

- 1,617 IPF facilities, with approximately 431 cases per facility, results in a total of 696,927 cases per year

- Beginning in FY 2018, participating IPFs will need to submit data on sixteen (16) measures. Because IPFs have been submitting eleven (11) of the sixteen (16) 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 five (5) new measures.

- We estimate that reporting data for the IPFQR Program measures can be accomplished by staff with a mean hourly wage of $16.42 per hour (previously $63.42).[2] Under OMB Circular A-76, in calculating direct labor, agencies should not only include salaries and wages, but also "other entitlements" such as fringe benefits.[3] This Circular provides that the civilian position full fringe benefit cost factor is 36.25 percent. Therefore, using these assumptions, we estimate an hourly labor cost of $22.37 ($16.42 base salary + $5.95 fringe). The BLS is "the principal Federal agency responsible for measuring labor market activity, working conditions, and price changes in the economy."[4] Acting as an independent agency, the Bureau provides objective information for not only the government, but also for the public. The Bureau's National Occupational Employment and Wage Estimates describes Medical Records and Health Information Technicians as those responsible for organizing and managing health information data. Therefore, we believe it is reasonable to assume that these individuals would be tasked with abstracting clinical data for these measures. In addition, the HIQR Program uses this wage to calculate its burden estimates, and we believe that the same staff would often be used to abstract data in the IPF setting.

-For this year's PRA package, we are adding the TOB-3/TOB-3a, SUB-2/SUB-2a, Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), and Screening for Metabolic Disorders Data Collection forms.

Changes to the Program for the FY 2018 payment determination, including more measures on which to report, leads to an increase in the total Program burden. For the FY 2018 payment determination and subsequent years, we estimate a total increase in burden of 174.4 hours per IPF or 282,004.80 hours across all IPFs, resulting in a total increase in financial burden of $3,901.33 per IPF or $6,308,447.38 across all IPFs. (See Table D)

[2] http://www.bls.gov/ooh/healthcare/medical-records-and-health-information-technicians.html.
[3] http://www.whitehouse.gov/omb/circulars_a076_a76_incl_tech_correction.

[4] http://www.bls.gov/bls/infohome.htm.

Table D

	Total Hours per IPF	Total Cost Per IPF	Total Program Hours	Total Program Cost
Prior Total Burden	1,192.5	$75,629.00	1,939,005	$122,971,697.00
New Total Burden	1,366.9	$79,530.33	2,221,009.8	$129,280,144.38
Amount of Increase	**174.4**	**$3,901.33**	**282,004.8**	**$6,308,447.38**

16. Publication/Tabulation Dates

CMS will not be employing any sampling techniques or statistical methods. However, CMS will allow IPFs to report data for certain measure using sampling.

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
4/2015	Proposed Rule Published
TBD	Final Rule Published
10/1/2015	Measures Publicly Announced
1/1/2016	Start of Reporting Period
12/31/2016	End of Reporting Period
7/1/2017	Begin Data Submission
8/15/2017	End Submission Deadline
8/15/2017	Deadline to Complete Data Accuracy and Completeness Acknowledgement (DACA)
April 2018 (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.