

**Supporting Statement – Part A**  
**Revised and New Procedural Requirements for the FY 2017 Inpatient Psychiatric Facility**  
**Quality Reporting (IPFQR) Program**  
**CMS-10432, OMB 0938-1171**

This package is associated with the August 22, 2016 final rule: CMS-1655-F, RIN-0938-AS77.

## **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 FYs, 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 2019. This package addresses the increase in burden associated with addition in the FY 2017 IPPS/LTCH PPS final rule of the SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered and Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge measure beginning with FY 2019 payment determination.

## **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 FY, 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.

The following is a list of measures included in the IPFQR Program and a brief explanation of their inclusion in this program.

- The Hospital-Based Inpatient Psychiatric Services (HBIPS) measures were chosen because The Joint Commission (TJC) has utilized them for several 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 and to identify areas of need for quality of care improvement, are valuable within all CMS-certified IPFs. CMS continues to require reporting on three of these measures (HBIPS-2, HBIPS-3, and HBIPS-5). 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](http://www.jointcommission.org/assets/1/6/TJC_Annual_Report_2011_9_13_11_.pdf).
- The SUB-1, SUB-2 and SUB-2a, and SUB-3 and SUB-3a 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 National Quality Strategy (NQS), and that these measures will help to improve quality of care and the patient-centered aspect of care across multiple settings. In this ICR CMS is adding the SUB-3 and SUB-3a measure for FY 2019 and subsequent years, SUB-1 as well as SUB-2 and SUB-2a were previously adopted and are continuing in the program. Documentation on the TJC website 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](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 National Quality Forum (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 previously unaddressed in the IPFQR Program, namely, ensuring that each person and family is engaged as partners in their 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 forms for the Influenza Vaccination Coverage Among Healthcare Personnel measure are maintained by the Centers for Disease Control and Prevention and can be found at <http://www.cdc.gov/vaccines/hcp.htm>.
- 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 specifications for these

measures can be found in the Hospital Inpatient Quality Measures Specifications Manual found at [http://www.jointcommission.org/assets/1/6/HIQR\\_Jan2015\\_v4\\_4a\\_1\\_EXE.zip](http://www.jointcommission.org/assets/1/6/HIQR_Jan2015_v4_4a_1_EXE.zip)

- 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 will afford consumers and their families or caregivers useful information in choosing among different facilities and will promote our NQS 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 a summary of the patient's record will be transmitted to his or her other treating facilities and physicians, improving care. This measure will also promote our NQS 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 antipsychotic medications. 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.
- The Thirty-day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF measure meets a key gap area in the IPFQR Program as identified in a January 2016 report from the Measure Application Partnership (MAP). This is an outcome measure which provides information regarding the quality of care for patients in the IPF setting. There is evidence that improvements of inpatient care can reduce readmissions. This, in turn, improves the patient's quality of life and reduces cost.

Section 1886(s)(4)(E) of the Act requires the Secretary to establish procedures for making public the data submitted by IPFs under the IPFQR 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 eighteen (18) quality measures for the FY 2019 payment determination. In addition, IPFs give their consent to publicly report their measure rates on a CMS website. CMS is 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 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; CMS-10210). 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 for 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 an 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 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 in the IPFQR Program (see section 12 of this document for a list of measures in the IPFQR Program) 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. For information about the updates to this program, as finalized in the 2017 IPPS/LTCH PPS Final Rule, please see Section 15 of this document.

### **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 on TJC measures 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 and Thirty-day All-cause Readmission Following Hospitalization in an IPF measures, CMS will collect such data using Medicare Part A and Part B claims; therefore, these measures will pose 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 data on measures considered to be meaningful indicators of psychiatric patient care by the NQF. To this end, we only require a single, annual report of measure data from facilities..

### **7. Special Circumstances**

Although IPF participation is voluntary (i.e., not required by Medicare Conditions of Participation), 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 FY 2017 IPPS/LTCH PPS final rule is serving as the 30-day Federal Register notice. The rule published August 22, 2016.

The FY 2017 IPPS/LTCH PPS proposed rule was placed on file for inspection on April 18, 2016. Comments were due 60-days later on June 17. No PRA related 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.

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

- We estimate that there are approximately 1,684 facilities eligible to participate in the IPFQR Program (increased from the previous estimate of 1,617 facilities based on more recent program data). Because historical data indicates that almost all facilities participate, and because we wish to be conservative in our estimates, we estimate that all eligible facilities will participate in the IPFQR program.
- We estimate that the average facility submits measure data on 848 cases per year for all of the measures except the Influenza Vaccination Coverage Among Healthcare Personnel

measure, the Assessment of Patient Experience of Care measure, and the Use of an Electronic Health Record measure (increased from the previous estimate of 431 cases per year based on more recent program data). For the Influenza Vaccination Coverage Among Healthcare Personnel measure, consistent with previous years, we estimate 40 cases per year. For the Assessment of Patient Experience of Care measure and the Use of an Electronic Health Record measure, consistent with prior years, since facilities are only required to submit an attestation, we estimate 0 cases.

- 1,684 IPF facilities, with approximately 848 cases per facility, results in a total of 1,428,032 cases per year.
- We estimate that it takes an IPF approximately 15 minutes (0.25 hours) for chart abstraction of a measure for collection based on new reporting requirements (increased from our previous estimate of 12 minutes, or 0.20 hours, based on more recent program data).
- We estimate an hourly labor cost of \$32.84/hour, see Section 12a of this document, below, for an explanation of this estimate.

#### **a. Estimated Wages**

We estimate an hourly base salary of \$16.42/hour which is based on the Bureau of Labor Statistics (BLS) wage for a Medical Records and Health Information Technician (29-2071). 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.<sup>1</sup> However, obtaining data on other overhead costs is challenging. Overhead costs vary greatly across industries and firm sizes. In addition, the precise cost elements assigned as “indirect” or “overhead” costs, as opposed to direct costs or employee wages, are subject to some interpretation at the firm level. Therefore, we have chosen to calculate the cost of overhead at 100 percent of the mean hourly wage. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method. In calculating the labor cost, we estimate an hourly labor cost of \$32.84 (\$16.42 base salary + \$16.42 fringe).

#### **b. FY 2019 Payment Determination and Subsequent Years**

##### *Chart-Abstracted Measure Data Collection and Reporting*

For the FY 2018 payment determination and subsequent years, we had adopted sixteen (16) measures. The following table sets out our estimated annual burden for each of these measures based on updated assumptions regarding the number of facilities, the number of cases per facility, and the effort per case. As indicated below, the FUH measure has no burden.

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<sup>1</sup> [http://www.whitehouse.gov/omb/circulars\\_a076\\_a76\\_incl\\_tech\\_correction](http://www.whitehouse.gov/omb/circulars_a076_a76_incl_tech_correction).

| NQF Number | Measure ID          | Measure Description   | Estimated Cases (per facility) | Effort per Case (hours) | Annual Effort (per facility) (hours) |
|------------|---------------------|---|--------------------------------|-------------------------|--------------------------------------|
| 0640       | HBIPS-2             | Hours of Physical Restraint Use   | 848                            | 0.25                    | 212                                  |
| 0641       | HBIPS-3             | Hours of Seclusion Use  | 848                            | 0.25                    | 212                                  |
| 0560       | HBIPS-5             | Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification  | 848                            | 0.25                    | 212                                  |
| 1661       | SUB-1               | Alcohol Use Screening   | 848                            | 0.25                    | 212                                  |
| 0576       | FUH                 | Follow-up After Hospitalization for Mental Illness  | 848                            | 0                       | 0*                                   |
| 1651       | TOB-1               | Tobacco Use Screening   | 848                            | 0.25                    | 212                                  |
| 1654       | TOB-2<br>TOB-2a     | Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment   | 848                            | 0.25                    | 212                                  |
| 1659       | IMM-2               | Influenza Immunization  | 848                            | 0.25                    | 212                                  |
| 431        | n/a                 | Influenza Vaccination Coverage Among Healthcare Personnel   | 40                             | 0.25                    | 10                                   |
| n/a        | n/a                 | Assessment of Patient Experience of Care  | 0                              | 0.25                    | 0                                    |
| n/a        | n/a                 | Use of an Electronic Health Record  | 0                              | 0.25                    | 0                                    |
| 1656       | TOB-3 and<br>TOB-3a | Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge   | 848                            | 0.25                    | 212                                  |
| 1663       | SUB-2 and<br>SUB-2a | Alcohol Use Brief Intervention Provided or Offered  | 848                            | 0.25                    | 212                                  |
| 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) | 848                            | 0.25                    | 212                                  |



| NQF Number | Measure ID | Measure Description  | Estimated Cases (per facility) | Effort per Case (hours) | Annual Effort (per facility) (hours) |
|------------|------------|--|--------------------------------|-------------------------|--------------------------------------|
| 648        | n/a        | Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) | 848                            | 0.25                    | 212                                  |
| n/a        | n/a        | Screening for Metabolic Disorders  | 848                            | 0.25                    | 212                                  |
|            |            |  |                                | <b>Annual Total</b>     | <b>2554</b>                          |

\*CMS will collect this data using Medicare Part A and Part B claims; therefore, the FUH measure will have no burden on IPFs.

For the 1,684 IPF facilities, the aggregate burden is 4,300,936 hours and \$141,242,738.

Beginning in FY 2019, CMS is adding two (2) additional measures. One of these measures is calculated by CMS using Part A claims, therefore this measure will have no burden on IPFs. These measures are listed below:

| <b>New Measures for FY 2019 and Subsequent Years</b> |                  |   |                                |                         |                                      |
|--|------------------|---|--------------------------------|-------------------------|--------------------------------------|
| NQF Number   | Measure ID       | Measure Description   | Estimated Cases (per facility) | Effort per Case (hours) | Annual Effort (per facility) (hours) |
| 1664   | SUB-3 and SUB-3a | Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge | 848                            | 0.25                    | 212                                  |
| n/a  | n/a              | Thirty-day all-cause unplanned readmission following Psychiatric hospitalization in an Inpatient Psychiatric Facility                         | 848                            | 0                       | 0*                                   |
|  |                  |   |                                | <b>TOTAL</b>            | <b>212</b>                           |

\*CMS will collect this data using Medicare Part A claims, therefore this measure will have no burden on IPFs.

For the 1,684 IPFs this new burden is 357,008 hours and \$11,724,142.72

### *Non-measure Data Collection and Reporting*

For FY 2019 and subsequent payment determinations, 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. This is consistent with policies for FY 2018 and subsequent payment determinations. We believe that the addition of one (1) chart abstracted measure leads to a net negligible change in burden associated with the

non-measure data collection. We previously estimated that it will take each facility approximately 2.5 hours to comply with this requirement.

| Tasks                                      | Hours per IPF | Total Hours for All IPFs | Wage Rate    | Cost per IPF | Total Cost for All IPFs |
|--|---------------|--------------------------|--------------|--------------|-------------------------|
| Non-measure Data Collection and Submission | 2.5           | 4,210                    | \$32.84/hour | \$82.10      | \$138,256.40            |

**c. Training**

Because IPFs have been submitting sixteen (16) of the eighteen (18) measures to CMS, and one of the new measures is calculated by CMS using Part A claims data, 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 one (1) new measure.

For existing facilities, the estimated burden for training personnel for data collection and submission for current and future measures is 2 hours per facility or 3,368 total hours. The cost for this training, based on an hourly rate of \$32.84, is \$65.68 for each IPF or \$110,605.12 for all facilities.

| Tasks    | Hours per IPF | Total Hours for All IPFs | Wage Rate    | Cost per IPF | Total Cost for All IPFs |
|----------|---------------|--------------------------|--------------|--------------|-------------------------|
| Training | 2             | 3,368                    | \$32.84/hour | \$65.68      | \$110,605.12            |

**d. Notice of Participation, Data Accuracy Acknowledgement, and Vendor Authorization Form**

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

**e. Burden Summary**

| 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 Reporting* (please note that these are average annual estimates) | 2766           | 4,657,944                | \$32.84/hour        | \$90,835.44        | \$152,966,880.96        |
| Training  | 2              | 3,368                    | \$32.84/hour        | \$65.68            | \$110,605.12            |
| Non-measure Data Collection and Reporting   | 2.5            | 4,210                    | \$32.84/hour        | \$82.10            | \$138,256.40            |
| <b>Totals</b>   | <b>2,770.5</b> | <b>4,665,522</b>         | <b>\$32.84/hour</b> | <b>\$90,983.22</b> | <b>\$153,215,742.48</b> |

\*Includes burden associated with the preparation and submission of the Notice of Participation, Data Accuracy Acknowledgement, and Vendor Authorization Form.

### **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 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 previously approved burden was based on 1,617 facilities submitting data on 431 cases for each of sixteen (16) measures per year. In the IPPS/LTCH PPS Final Rule published on August 22, 2016 for the FY 2019 Program CMS increased this to eighteen (18) measures from 16. CMS also updated the estimates based on new program data, these updates are as follows:

- There will be approximately 67 additional IPFs (1,684 facilities) nationwide eligible to participate in the IPFQR Program.
- The average facility will submit measure data on an additional 417 cases per year (for a total of 848 cases per year).
- Each IPF will take an additional 3 minutes per case to abstract data (for a total of 15 minutes).

Using these estimates, we calculate that the annual effort per facility for each chart abstracted measure is 212 hours. Only one of the two newly proposed measures is chart-abstracted, the other, Thirty-Day All Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF, is calculated by CMS using Part A claims data. The total burden, per facility, for the newly adopted measures is detailed below.

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) |
|------------|------------------|---|--------------------------------|---------------------|------------------------------|
| 1664       | SUB-3 and SUB-3a | Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge | 848                            | 0.25                | 212                          |
| n/a        | n/a              | Thirty-day all-cause unplanned readmission following Psychiatric hospitalization in an Inpatient Psychiatric Facility                         | 848                            | 0                   | 0*                           |
|            |                  |   |                                | <b>Annual Total</b> | <b>212</b>                   |

As described in section 12 of this document, we estimate an hourly labor cost of \$32.84. This labor cost applied to the 212 hours of added annual effort per facility for the FY 2019 payment determination and subsequent years results in an annual cost per facility of approximately \$6,962.08. Across all 1,684 IPFs nationwide, this totals \$11,724,142.70 increase in burden associated with new measure collection and submission.

Because IPFs have been submitting sixteen (16) of the eighteen (18) measures to CMS, and one of the new measures is calculated by CMS using Part A claims, 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 one (1) new measure.

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 \$32.84, is \$65.68 for each IPF, which totals \$110,605.12 for all facilities.

For the FY 2019 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 only adding one measure for which this reporting is required, we believe this leads to a net negligible change in burden associated with non-measure data collection.

Therefore, we estimate a total increase in burden of 214 hours per IPF or 360,376 hours across all IPFs, resulting in a total increase in financial burden of \$7,027.76 per IPF or \$11,834,747.84 across all IPFs.

| 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 | 212        | 357,008        | \$32.84/hour | \$6,962.08        | \$11,724,142.72        |
| Training  | 2          | 3,368          | \$32.84/hour | \$65.68           | \$110,605.12           |
| <b>Totals</b>   | <b>214</b> | <b>360,376</b> |              | <b>\$7,027.76</b> | <b>\$11,834,747.84</b> |

## 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, CMS will publicly display the measure rates on the CMS website. The following is the planned schedule of activities to reach these objectives.

| <b>Date</b> | <b>Scheduled Activity</b>  |
|-------------|--|
| 4/15/2016   | Proposed Rule Published  |
| 8/1/2016    | Final Rule Published   |
| 10/1/2016   | Measures Publicly Announced  |
| 1/1/2017    | Start of Reporting Period (for most measures)*                             |
| 12/31/2017  | End of Reporting Period*   |
| 7/1/2018    | Begin Data Submission*   |
| 8/15/2018   | End Submission Deadline*   |
| 8/15/2018   | Deadline to Complete Data Accuracy and Completeness Acknowledgement (DACA) |
| FY 2019     | Public Display of data on <i>Hospital Compare</i> **                       |

\*Influenza Vaccination and Influenza Vaccination Among Healthcare Personnel are collected on a different schedule

\*\*Specific display date to be announced via subregulatory guidance

## 17. Expiration Date

We will display the expiration date on associated forms.

## 18. Certification Statement

There are no exceptions to the certification statement.

## B. Collections of Information Employing Statistical Methods

Not applicable to this collection.